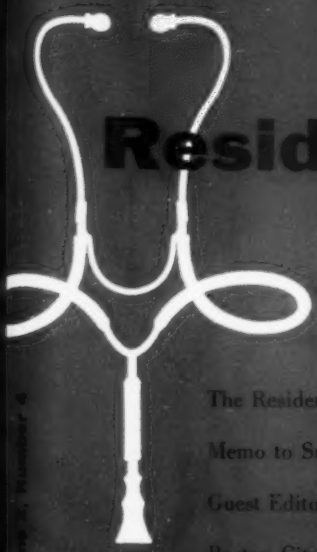

Resident Physician

Journal for the Hospital Resident

sugar and spice and . . . gastric hyperacidity

Nice to taste . . . difficult to digest . . . the result, more often than not, will be gastric hyperacidity. Bad experiences and good intentions notwithstanding, this particular chain of misfortune is likely to recur. With Gelusil, however, excessive gastric acidity—whether acute or chronic—can be quickly and pleasantly relieved.

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WARNER-CHILCOTT

Resident Physician

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Articles

April 1956, Vol. 2, No. 4

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months?

years?

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Older patients with fractures, particularly of the hip, respond well combined estrogen-androgen therapy. The prognosis for bone recal fication is good provided treatment is continued for extended period

*Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, ed. 2. N York, The Blakiston Company, Inc., 1954, chap. 98, pp. 702, 703.

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Excellent preparation for estrogen-androgen therapy

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5647

Resident Physician

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Departments

Journal for the Hospital Resident

Resident Physician

April 1956, Vol. 2, No. 4

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians. When possible, two copies of the manuscript should be submitted. Articles with photographs, illustrations or drawings are especially desired.

RESIDENT PHYSICIAN

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an agitated senile patient

. . . "no longer a disturbing element in the family"

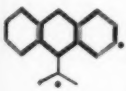
Typical 'Thorazine' Case History

patient: "This 72-year-old woman babbled constantly. She would hit at anyone who came near her and allowed no one in the home to touch the television or telephone. Her family contemplated having her committed."

medication: 'Thorazine', 25 mg. orally, t.i.d.

response: "Within a week her hyperactivity diminished. She became calm and friendly and spoke in a coherent manner. She was no longer a disturbing element in the family. . . . Six months after the start of treatment she continues to remain relatively free from symptoms."

THORAZINE*



is available as the hydrochloride in ampuls, tablets and syrup; and as the base in suppositories.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.
This case report, from a general practitioner, is in his own words.

a "judicious combination..."

for antiarthritic therapy

SALCORT*

That cortisone and the salicylates have a complementary action has been well established.[1-5] In rheumatic conditions, functional improvement and a sense of feeling well are noted early. No withdrawal reactions have been reported.

One clinician states: "By a judicious combination of the two agents . . . it has been possible to bring about a much more favorable reaction in arthritis than with either alone. Salicylate potentiates the greatly reduced amount of cortisone present so that its full effect is brought out without evoking undesirable side reactions."[1]

INDICATIONS:

Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Bursitis . . . Still's disease . . . Neuromuscular affections

EACH TABLET CONTAINS:

Cortisone acetate	2.5 mg.
Sodium salicylate	0.3 Gm.
Aluminum hydroxide gel, dried .	0.12 Gm.
Calcium ascorbate	60 mg.
(equivalent to 50 mg. ascorbic acid)	
Calcium carbonate	60 mg.

* U.S. Pat. 2,691,682

1. Busse, E.A.: Treatment of Rheumatoid Arthritis by a Combination of Cortisone and Salicylates. Clinical Med. 11:1105 (Nov., 1955).
2. Roskam, J., VanCawenberge, H.: Abst. in J.A.M.A., 151:248 (1953).
3. Coventry, M.D.: Proc. Staff Meet., Mayo Clinic, 29:60 (1954).
4. Holt, K.S., et al.: Lancet, 2:1144 (1954).
5. Spies, T.D., et al.: J.A.M.A., 159:645 (Oct. 15, 1955).

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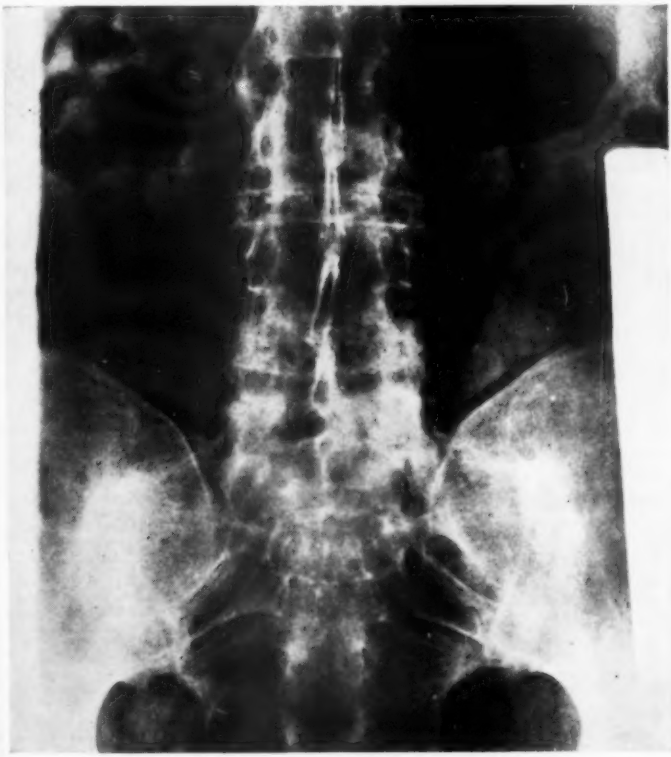
Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

Which Is Your Diagnosis?

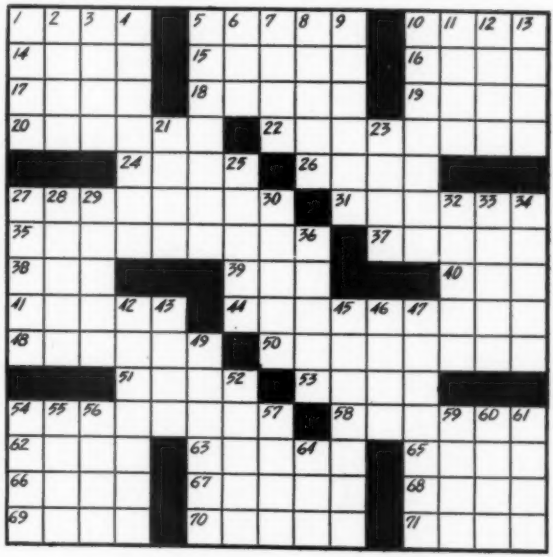
1. Osteomyelitis of spine
2. Osteoporosis of spine
3. Osteoarthritis
4. Marie-Strumpell's disease

(Answer on page 130)



Resident Relaxer

(Answer on page 130)

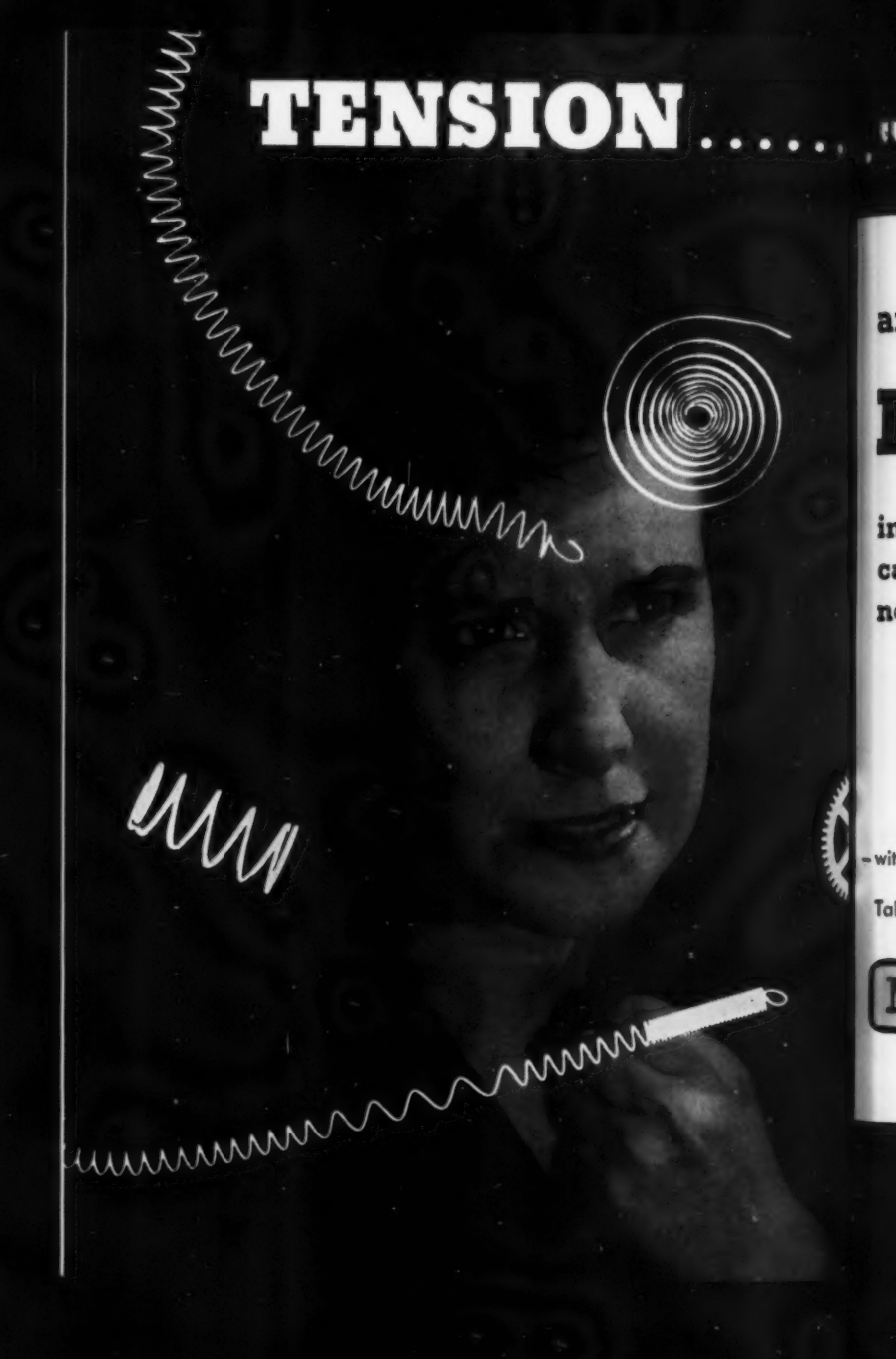


ACROSS

1. German title of nobility
5. Billiard shot
9. Ceylonese monkey
14. National Foundation for Infantile Paralysis needs ——— money
15. Synthetic fiber
16. Electric od (Abbr.)
17. Roaster
18. Landed proprietor
19. Moist
20. Tooth (Comb. form)
22. Foreskin (Pl.)
24. Attractive by reason of daintiness
25. Aromatic hydrocarbon radical
27. What polio vaccine produces
31. Pertaining to pituitary site
35. Founder of the NFIP
37. ———tia, joy (Lat.)
38. Liver fluke disease
39. Annamese tribes
40. ——oplegia, one-extremity paralysis
41. Oklahoman Indian tribe
44. Showed that Eastern cotton rat can be given polio
48. Thomas H. ———, sharer of 1954 Nobel Prize for polio research
49. Cells directly attacked by polio
51. River (Tagalog)
52. Draw out and twist wool
54. —— to polio, not uncommon in summertime crowds
58. Pyrexia
62. Medicinal drinks made from herbs
63. —— Globulin
65. ——nthe, Gilbert and Sullivan operetta
66. Aoudad
67. ——ropia, normal refraction of the eye
68. ——para, Childless woman
69. ——erol, Muscle relaxant
70. Separate a tissue for microscopic examination
71. Search

DOWN

1. ——spasm, Rotatory spasm of the head
2. Crucifix
3. ———nomic nervous system
4. Man in charge of evaluating polio vaccine trials
5. Russian foreign minister
6. Greek goddess of vengeance
7. Worsen
8. Blessing
9. Harvard virologist, sharer of 1954 Nobel Prize for Polio research
10. Nerve center involved in severest polio cases
11. Man's nickname
12. Bodian and Howard —— concluded that polio virus belonged to 3 types in respect to immunity
13. Malabar linear measure (Pl.)
21. Roller —— Technic, mass production method of growing polio virus
23. Denoting renal pelvis (Comb. form)
25. Dropsy
27. Caustic rod for insertion into tumor
28. Hanging device
29. Sum
30. Lost (obs.)
32. Source of succus limonis
33. Expiate
34. Marginal growths of liquid bacterial colony
36. "Medical ——" G.P.'s indispensible monthly
42. Tumorous neuroglia disease
43. Mature elvers
45. Salt of sulfuric acid
46. —— Pelvis, Pelvis minor
47. Frederick C. ———, sharer of 1954 Nobel Prize for polio research
49. Leptus autumnalis
52. Misery (Arch.)
54. —— Mamelonne, chronically inflammed gastric mucosa
55. ——stoma, Dry mouth
56. Hammon, and Yale's —— showed polio to be as old as civilization
57. Novel by Jane Austin
59. Rake
60. That one (Fr.)
61. Man behind history's biggest "monkey business"
64. ——encephalon, midbrain


TENSION

Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request your name will be withheld.

Intern Copies?

I am very much interested in your publication, but there is just one issue in the hospital library and other issues are kept by the residents to whom mailed for their own use. . . . I am serving a rotating internship at present though I will go into residency next year. I will be very much obliged to you if you can send your journal to me regularly.

Dr. I. Ozman

Aultman Hospital
Canton, Ohio

Although many interns have asked to be included in our circulation, we regret we are not set up to handle this important group at the present time. We have attempted to provide every residency-approved hospital with a copy of RESIDENT PHYSICIAN *each month for its house staff library. We have also learned from a recent survey of our readers (the results of this comprehensive survey of residents will appear in coming issues of RP) that more than 40% pass their copies along on loan to interns and medical students. Perhaps, if you ask a resident to loan you his copy regularly, you can assure yourself of seeing each issue. We are encouraged by this interest on the part of interns and students and hope our residents will cooperate in sharing their copies wherever possible.*

Photos Anyone?

I am interested in photography as a hobby. I think many other residents are, too. Why not start a photography contest?

Leonard T. Ayres, M.D.
New Orleans, La.

All those in favor please signify by dropping us a note. Also, include any suggestions as to categories.

No Technical Papers

We would like to have you know how much we have been enjoying your publication. It would be difficult indeed to suggest features that

—Continued on page 26

ACHROMYCIN*

Tetracycline *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

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ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

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Dry filled sealed capsules

1January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

Lederle

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*REG. U.S. PAT. OFF.

PHOTO DATA: 4X5 VIEW CAMERA, F5.6, 1/25 SEC., EXISTING LIGHTING AT DUSK, ROYAL PAN FILM.

Continued from page 22

would be of more interest to residents. We also appreciate your keeping the technical papers out, as there are already 2,000-odd journals in that field.

Joseph Onorato, M.D.
Resident in Medicine
Richard J. Weaver, M.D.
Resident in Pathology
St. Elizabeth Hospital
Lafayette, Indiana

Assistance

Your magazine is certainly an answer where there was a need. I wish I had had it during the rest of my four years instead of at the end. Next summer I plan on opening an office in Wisconsin and confining myself to Allergy. Can you . . . direct me to some agency who could supply me with information concerning allergy office arrangement, planning and organization? I should be very grateful for any information you could supply me.

James C. Curry, M.D.
Charlottesville, Virginia

A special chapter providing the information you require may be found in "A Manual of Clinical Allergy," by Sheldon Lovell Mathews, published by W. B. Saunders, 1953.

Cover-to-Cover

I was delightfully impressed since the first appearance of our magazine, so witty as well as useful to all of us; you can be actually sure that it has been read from cover to cover for it is so well-written and presented. Congratulations to the staff, and my wish that our publication will continue its success as deserves a journal such as that.

Efrain Osejo, M.D.
Sibley Memorial Hospital
Washington 2, D. C.

Vacuum

I would advise any physician to think twice before accepting a Children's Camp job. Many camps are somewhat isolated and one can never tell who his companions at camp will be. This frequently results in an intellectual and social vacuum, making for a very, very dull summer.

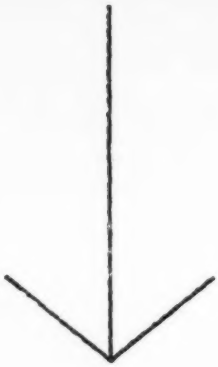
Melvin L. Selzer, M.D
Ypsilanti State Hospital
Ypsilanti, Michigan

Resident article

I have an idea for an article. It's non-medical and I think it might help other residents in solving their financial difficulties. Are you interested?

William L. Minot
Los Angeles, Calif.

But definitely. Our sole criteria for article selection: Will it interest resident readers? About 2,000 words is fine for length. Payment will be made promptly upon acceptance by the editorial board. You needn't be a Pulitzer prize-winning writer to contribute.



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Original Research in Medicine and Chemistry

Perrin H. Long, M.D.

Editor's Page

Medicine, A Learned Profession?

I SOMETIMES wonder in this day and age, whether medical students, house staff and practicing physicians ever think of the fact that they are representatives of one of the three so-called "Learned Professions." (The other two: Theology and the Law.) As such, we are supposed to be *educated* individuals who think and speak logically. Maybe we all just assume that such is the case, because the majority of us hold a collegiate as well as a medical degree.

But if what I hear on ward rounds or at medical meetings is a sample of the *learning* of our profession, I must say that at times I am ashamed. Why we resolutely and repeatedly speak a jargon rather than use good plain English or American is beyond me. And when I say this, I am not thinking of the medical student who is gaining a pleasurable oral sensation by mouthing "adiadochokinesis" for the first time. I will give you an example of what I mean.

The other day while on ward rounds, I heard a phy-

sician making some "learned" observations: "The patient was *nauseous* but did not vomit." Interesting? He continued, "The heart was negative, but she has *three-pillow orthopnea, two-flight dyspnea* and a *three-finger liver*"! Which pillows, what flights and whose fingers? Think about the size of pillows, the varying length of flights of stairs, the width of fingers, and also the damage to the precision of description necessary to the practice of medicine.

The physician continued, "A *battery* of *liver chemistries* was done to determine the *liver profile* and at the same time we *drew* a blood culture." Finishing strong, he pronounced as follows: "Eventually, because she did not become *asymptomatic*, a surgical *consult* was asked for, and *the surgeons opened her up*"!

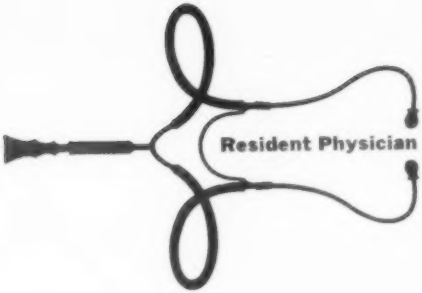
I hope, as my friends from Tamaqua, Pennsylvania, used to say, the surgeons "made the door shut" after they *opened her up.*

To me, this is a serious matter; and along with the increasing use of unintelligible abbreviations (CVA—cardiovascular accident, costovertebral angle, cerebral vascular accident), it represents a trend in medical thinking today which is reducing the learned profession of medicine to the status of a trade.

Clear thinking, *as reflected by the proper expression of ideas*, is the sign of an educated person. Since physicians are generally considered to be educated, it would seem we'd better rid ourselves and our profession of meaningless jargon and double-talk before we become entangled in a mystic language of generalizations and obscurities of our own creation.

The pure and complete form of English-medical terminology is purposeful and intelligible. It may not be cute or clever—but it has the supreme advantage of being impossible of misinterpretation.

Perrin H. Long.



The Resident Buys a Used Car

It will take you time and a heap of learning to come out a winner. But if you paste a few rules in your hat before you start, you'll at least increase the odds in your favor for a better deal

More than 10,000,000 Americans bought used cars last year. And, if you could tabulate the reasons given by each purchaser for selecting his particular car, you would come to the conclusion that, "a car is many things besides transportation."

For example, are you buying your used car because you need it to produce income? Probably not. Do you want a used car solely to get you to the hospital and home and back again? Again, your answer would probably be no. Actually, you want a car for a combination of purposes, most people do. But if you're wise you'll put first things first, and pick your car accordingly.

If your car is to be used partly for commuting and partly for recreation, you might best begin by estimating the percentage of time involved in each category. With this information as a background you are in a better position to determine what you actually want in a car. In other words, since you already know your financial limit, in what other ways can you cut the used car field down to size? Which is most important to you: comfort, power, dependability, safety, economy, style, or prestige of ownership?


USED CARS

Though the last mentioned would hardly seem to be your particular need, you might be surprised at how many people let prestige force their purchase of an automobile.

Strictly as a practical matter, prestige should be the last thing you ought to consider.

Remember, what you derive from your car will certainly be at a sacrifice of something else.

Investment

One other way in which to consider your used car purchase is as an investment. This is kind of rough to figure. It means projecting present conditions into the future, and considering such elusive and illusory items as probable depreciation between the time you buy and the time you might expect to sell. It also means choosing the make and model of automobile which would hand you the lightest licking when you sell.

Certainly any automobile is an investment. That is, you can be sure you can get *something* for any car you buy when you're ready to sell it, even if in the meantime you turn it into a piece of junk.

Personal satisfaction

Yet, most experts advise that your choice, in the final analysis, should be based on the car you really want. A car you'll be happy with, even if it costs you a few dollars extra, is a lot better than a car you wish you'd never bought. If every time you look at your car you say to yourself: "I wish I'd gotten that big Buick," then chances are you'd have been lots smarter to have put up the extra dollars and grabbed the Buick of your dreams. Remember, even if the car you want turns out to be a real clinker, it'll be a lot easier to live with than one which you didn't want in the first place.

Perhaps the first question you should ask is should you buy a used car in the first place. Well assuming you have no outside income, that you depend pretty much on your resident stipend to get by (with perhaps a great big assist from your wife's job) then you're strictly in the used car market.

All the fancy whoop-de-doo, classy adjectives, and the big circus of promotion involved in advertising the new models may be something for you to hang your dreams on. But that's all. For unless you can take the shock of $500-$1200 worth of depreciation *in the first year of ownership*, you just aren't ready for the new car market. (And those new cars are really advertised! The motor car companies picked up the tab for some 32% of all TV sponsorship last year.)

Actually, then, the main reason you're in the used car market is because you can't afford a new car . . . unless, of course, you intend to spread a new car's depreciation over a good many years of ownership.

Where?

So where do you find your used car? Basically, there are three markets. You can get used cars from those dealers who handle new cars and take used ones in in trade. You can also buy from those who deal in used cars exclusively. Finally, you could get your used car from an individual, that is, the former owner of the particular car you want to buy. What's your best bet?

New car dealer

The new car dealer usually has a repair shop and a reputation. Both help to protect you. You can check the new car dealer's business standing through the Better Business Bureau. At times (like right now, for instance), you may find that he is under pressure to turn over his used cars rather than build this inventory all out of proportion to his investment. He's pressing to sell new cars, too.

Some of his used cars have been "reconditioned." This of course means many things to many dealers. But at least he is in a position to give you a guarantee on repairs and be able to back it up, through his own repair shop facilities.

Frequently, and this can be a big help, the new car dealer knows the original owner of the used car you are interested in. He may let you contact the original owner on your own so you can get an "objective" opinion on the car's performance from its original owner (who should have no ax to grind since he's already gotten rid of the car). Generally the former owner will give you a straight story. But remember, he's no mechanic.

Used cars only

How about the dealer who handles used cars only? He has no new car business as a profit cushion or drag, as the case may be. He must buy and sell close to the bone. If he has been in business a long time, he must be giving reasonable values in order to keep going. And that's an important point. Before you buy, check to see how long he's been in business. Ask around concerning his reputation. There is one advantage: the used car dealer can pick and choose the cars he takes in to sell. He's under no pressure to take just "anything" in order to sell a new car.

Private party

Now, how about the private owner? Maybe he's a friend of yours. Maybe you think you know his driving habits; chances are you won't know his maintenance habits though. But

According to a recent survey, better than 40% of all people buying new cars traded in their old cars simply because they wanted a new car. They considered their old car *still dependable.* The average age of cars turned in was under four years.

anyway, you're probably better off dealing with a close friend who wants to stay friends. He'll tell you everything he *knows* of that needs fixing. In that way you can come closer to a fair appraisal of the car's worth.

How about the private owner whom you don't know personally? Go slow! Remember he can't make good any guarantee he gives you. He has no repair shop. Also, you'd probably hesitate to force him to make good on anything he tells you —even if he put it in writing. Generally he knows some of the things wrong with his car. (Sometimes he can do an awfully good job of keeping you from finding out.) This fellow is more apt to adopt the "man-to-man" attitude. Beware, brother, beware! No matter who you deal with in buying a car, forget the buddy-buddy approach. It's a business transaction plain—but not simple. You're putting a lot of money into the transaction. Don't attempt to spare feelings by giving his heap a casual, superficial inspection just so he won't think you're trying to find something wrong. You *are* trying to find something wrong. *Everything* that *is* wrong.

"Good" used cars

Is there such a thing as a good used car? Definitely. And, according to used car experts, there is more value in the average three- or four-year old used car today than there ever was in the past. One reason is that in a time of rising income, people tend to up-date their car ownership, turn their cars over more frequently, keeping in a new model as far as possible. You're well aware that many people will go 'way over their heads financially to get and keep a new car.

As a *used car* buyer, this is all in your favor. Lower mileage cars are more common, and on our trunk-to-bumper parkways, cars take nowhere near the beating they did on the washboard roads of only fifteen years ago. Any 25,000 miles on a car today is generally easier than was 10,000 put on a 1941 automobile.

Short cut

If you have an idea of what make or model car you want, you are ahead of the game. It helps if you can cut the area of investigation to reasonable dimensions. After all, you're going to spend quite a bit of time shopping for your used car. There's no sense in spending your life at it. That's what it would take if you tried to study all the years of all the makes of all the models that you will run into in the various car lots.

Models

Do you want a two-door or four-door? Structural rigidity is fairly good in both. Hard tops and convertibles, on the other hand, are not as sturdy. The latter have

The new-car buyer doesn't have it all roses and cream. But rarely will you hear him complain about the expenses of minor repairs in his first year and a half of ownership.

As a matter of fact, due to the human propensity for forgetting the unpleasant, he may very effectively dis-remember most of these minor complaints. But remember, everything he has fixed, he has fixed for you if you are buying the used car.

squeaks, leaks and rattles — as do station wagons. Weight is no guide to value. Convertibles are "beefed up" to make them more "solid." Actually all that's accomplished with the extra weight is to load down undersized tires; and you pay to carry this added weight around. Convertibles, known as ragtops in the trade, are costly to buy, expensive to maintain, and not too safe in a rollover accident.

If you want a convertible, get it in January, not in the summer. Convertibles are a drug on the market in the winter months, prices are usually down.

New station wagons are in demand. But as used cars, they seldom represent real value for your dollar. They come high, and often you get one only after it has absorbed some pretty rough treatment. There are, of course, exceptions. Two-doors generally cost from $25 to $50 less than the four-door models in the used car market.

So let's suppose you've decided on a four-door car in the medium price range. That is, as a *new* car it may have been in the middle bracket, but as a used car you may be surprised at how depreciation has brought it within your financial reach.

Price guide

Before you start lot-hopping, get yourself equipped with a buying guide. The "bible" of the used car market is called the Red Book National Used Car Market Report. It's out eight times a year; prices are based on actual prices paid to used car dealers all over the United States. Actually there are three editions to cover the different sections of the country, since prices differ from coast to coast.

Some forty-two separate makes of passenger cars, domestic and foreign and all models for the preceding ten years are listed.

Generally you will find four prices given for each model and year: (1) The *average retail* price. This is the average of all prices paid to dealers for each model and year for every car, as reported by used car dealers. It's not the price you would get. It is a general price by which you should be guided in your purchase. (2) The "*as is*" price. This is a the average retail price. It's the *wholesale* price about 20% below

minimum price you may expect for your used car if you were to *sell* it. The difference is the dealer's margin, covers reconditioning and other sales expenses, plus his profit. (3) The *list* price. This is the price of the car when new. (4) *Average loan.* This is the amount you might expect to borrow when you're buying the used car. It's usually about two-thirds of the *retail* price.

Besides the above, the book shows the extra prices involved for such things as automatic drive, power steering, radio and heater, overdrive, etc.

The point you should remember is that you're negotiations should start with the "as is" price as a base. Also remember that this publication is a guide, *not* an official price book.

The Red Book is almost a must if you're going to buy a used car. How do you get one? That's the problem. If you can get one a month or two old from your dealer, with a little interpolation you can bring it up to date for the particular model and year in which you're interested. Besides making interesting reading, this book will help you walk into a used car lot with some knowledge of what you *should* be paying for a particular car.

Newspapers

If you can't get a copy, use your local newspaper as a guide. When you see a model advertised in which you're interested, make a note of the price, and the accessories included in this price. Then subtract 15% of this price as a basic figure with which to start your dealings. Remember all advertised prices are simply that. You'll find plenty of room to negotiate beneath the advertised price.

There's a lot of variation in what one might call "used." There's the car that the poor little old widow keeps in the garage year in and year out and after five years has put only 1,000 miles on the speedometer. The only trouble is "you just don't hardly get them no more." . . . it's doubtful if anyone ever did. And if anybody tells you he knows of such a deal, just tell him "fine" and quickly change the subject.

Then of course there's the salesman's car which the dealer has "doctored-up." You would be amazed at the breath-taking ease and rapidity with which a car with 100,000 miles on it can be shined up and made to look (to the casual used car buyer) as if it were driven a very careful 15,000 miles.

Repair fund

Regardless of which used car you buy, allow at least 15% of the purchase price as money to keep aside. This is what you can expect to pay to bring your used car into the shape you want it. No matter in how fine a condition it may appear to be, there are things you'll want done to put it in top condition.

Thus, if you're paying $800 for a used car keep $120 in cash to use for immediate repairs and fixing up. The figure may seem excessive but experts will tell you that it will come out just about perfectly.

Condition

Forgetting what the "Red Book" might indicate as the price, and no matter what price you are asked to pay, one factor is most important in your selection of a used car. *The condition of your particular choice outweighs all other considerations, bar none.* Very often, two cars of the same make, model and year will be priced exactly the same, yet, condition-wise, one will be worth 30% more than the other. Any bargain you get will be determined by a combination of price and condition.

How do you check the condition? One simple way: If you've already picked out a car, get the dealer's permission to test drive it for an hour. (He should not object to this—if he does, forget the car.) Make sure you are covered by insurance before you drive it out of the lot. Then, head for a reputable garage. By offering to pay for the mechanic's time you can get an expert to put your prospective purchase through its paces. It'll be well worth the $5 or $10 it will cost you to find out the car's condition.

Another way to check is to set up your own test program. The second part of this article (to be published in our May issue), will give you a detailed point-by-point checklist to help you in your inspection of any car you wish to check over.

Final note

If you do take a car out for a test, don't be conned into making a down payment with a proviso that you can use it against another car if you decide you don't like the first car you're testing. The only time you want to put cash on the barrel-head is *after you've definitely made up*

From a background of twenty years in practice, one physician offers this advice: "As a resident, I would drive anything that was fairly dependable and as safe as an expert mechanic could make it.

"In my first year of practice, I would be certain *not* to get a brand new red and cream Holiday convertible or Coupe de Ville —because, even if I could afford it, none of my prospective patients would be convinced that their pocketbooks wouldn't feel the effect.

"And as an established physician, I wouldn't give a damn what anyone thought I *should* drive, I'd get any car I wanted and felt I could reasonably afford.

"Personally, I don't drive at all anymore. Too dangerous. My wife does, though. So she picks the car—and I just go along for the ride, and of course, pay for the gas."

your mind you want a particular car, and it's presently in the condition that you want it.

Things to watch for

Some makes of cars give you excellent value as used cars because they are in *less demand* in the used car market, not necessarily because they are mechanically poor as a used car. For instance, in the case of certain high-priced automobiles, the people who buy them new are looking—among other things—for prestige. The secondhand shopper who buys this high priced (originally) car often gets a good bargain because the biggest slice of depreciation has already knocked the price way down. But, remember, these big babies cost more to fix when something goes wrong.

A new kind of shop has started up recently. It's called a "used car inspection" service. For a fee of $10, a mechanic takes your car on the road for a test drive. Back in the shop, he gives it a complete check, puts it on the lift, goes over the motor, electrical system, etc. In all, he may make fifteen or twenty separate checks which he notes on a printed form. He also will rate the overall condition of your car. The service is being started up in various areas of the United States. Sometimes the $10 bill can save you three or four hundred dollars.

Your local Chamber of Commerce may know if such service is available in your area.

When should you buy?

The biggest turnover in cars is when the new models come out, and again in the Spring and Summer. Yet none can say just when in any particular year, car prices will be lower. Used car prices are linked with new car prices, but not absolutely. Your best time to buy would generally be when dealers are having difficulty selling new cars or, when they are being delivered more new cars from Detroit than they can get rid of easily. This often means that used cars are also piling up on the lots. At these times, most dealers are anxious to sell and will make you a better deal.

It looks as if the new 1957 models will be out even earlier than the 1956 new models. This means that either now or towards the end of this Summer would be a good time to get excellent dollar value in your used car purchase.

On your mark . . .

The used car market has been compared to the Sargasso Sea; you'll find no landmarks, see no friends, and be under the constant influence of hot air. You'll continually be asking yourself: is *this* a good buy? How can I know for sure? The answer is that you can never be positive, just reasonably certain. After a full year of owner-

ship you'll know one way or the other—but not before.

However, anyone that's never been in the used car market will tell you that most used car dealers are horse-traders at heart. There is a lot of give and take and lots of room for bargaining back and forth.

But, the dealer is the expert. You're the amateur. So it stands to reason you'll have to smarten up, get some facts to work with, learn a few tricks of the used car business before you go shopping.

The second part of this article (next month), should give you valuable pointers; help you stay clear of the real clunks and junks. And with an educated eye for mechanical defects, and a working knowledge of prices, you will be able to weed out the bad from the good—and pick yourself up a good buy in a used car.

NEXT MONTH: Checklist for inspecting used cars. How to pick the best of the bunch, and how much you might expect to pay for various makes and models. Also, what it really costs to own and operate an automobile.

Ob-Gyn Applications

Applications for certification by the American Board of Obstetrics and Gynecology for the 1957 Part I Examinations are now being accepted. Candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is October 1, 1956. Application for re-examination, as well as requests for re-submission of case abstracts, must be made to the Secretary prior to October 1, 1956. Current Bulletins outlining present requirements may be obtained by writing to: Robert L. Faulkner, M.D., Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

Memo to Summer Camp M. D.s

A recent article in Resident Physician (February 1956) urged residents to seek positions as summer camp physicians before going into practice. Having had summer camp experience, the author commends the idea highly. But he points out many things he had to learn the hard way

Norman Ronis, M.D.

In many ways, summer camp jobs can be a bonanza for the financially hard-pressed resident. Not only for the one who plans to start his practice in the Fall, but also for those who find themselves in first-class hospitals . . . at low stipends.

A season, or even half a season, of doctoring in a camp can be a big help in buying equipment, paying off a debt, or in acquiring that hi-fi set. Why mention half a season? Because that's one way for two residents still in training to split a summer. Practically no service can give a resident eight weeks of leave. But, recognizing his financial problems, many a service will manage to give a man three-and-a-half or four weeks, including vacation time. Thus, two residents might each take half the season at one camp, this would satisfy the camp director, and of course make two residents a little more solvent than most of us manage to be.

Before signing

One very important suggestion: as the article in the February RESIDENT

ABOUT THE AUTHOR—*Dr. Ronis is a resident in neurosurgery at the New England Medical Center. Having been a camper, camp counselor and camp physician in turn, he bases this report on his own experience. His most recent tour of duty was last summer as camp doctor in western Massachusetts.*

PHYSICIAN urged, make all your agreements with the camp director before you sign the contract. Make sure that any items likely to be the objects of dispute are in writing.

Time off has to be dealt with very specifically, since many camps are really "in the woods," and it may be next to impossible to get a local doctor willing to cover for you during your off time. You might, for example, arrange to have a Red Cross Water Safety Instructor (there's at least one in every good camp) always in camp and available when you are out. They are generally pretty well informed in first aid, and will be able to handle most types of emergencies until you can get back.

When you do leave camp, make sure you can be reached, just as if you were in private practice. You probably won't be disturbed on a single evening all summer long. Practically nothing, in my experience, comes up after the kids are in bed that can't wait for your return.

Local M.D.

If you are lucky enough to have a local doctor nearby who is willing to cover, a note to him before the season begins would be a good ice-breaker; that "LMD" down the road can be a mighty big help when you are faced with an unfamiliar situation or an irate parent who doesn't trust "such a young doctor."

Here is something not to be overlooked. Make certain there is going to be a registered nurse in the camp, and preferably also a nurse's aide of some kind. Otherwise you may find yourself carrying trays and making beds—and you wouldn't be the first camp doctor it happened to, either.

License check

Before you sign anything, check with the Board of Medical Examiners in the state where your prospective camp is located, just to be certain of their current official policy in regard to temporary practice with an out-of-state license. If you have a license in the same state, it is all to the good. (Here's where that LMD I mentioned might come in handy—writing that occasional special prescription which not even the friendly local pharmacist can fill without knowing the signer is licensed in his state.)

When all the preliminaries are straightened out and you've signed a contract for the summer, or part of it, don't just sit back and wait for those lazy, fun-filled weeks to begin. They won't be lazy, believe me, although there is a better than even chance that you'll have plenty of fun. The earlier you sit down with the camp director—the head counselor should be in on this, too—and discuss your particular end of the camp season, the better. Before you do, however, you should have a pretty good idea of what you will want around by way of supplies and equipment. A basic list, such

as that found in the Merck Manual, is an excellent guide.

Supplies

It should be understood beforehand, between yourself and the camp director, that you can order whatever you judge necessary from any source he may designate. Of course, you are expected to be reasonable about this, and whatever you *do* order should be for the immediate treatment of campers and staff. Perishable supplies, stored from the summer before, should be replaced by fresh stuff. This sometimes makes camp directors unhappy, but you can always make your point by opening an ancient package of plaster splints and presenting him with the rocky and useless contents.

Tour of inspection

A pre-season visit to the camp, if it can be arranged, might be a good idea. Remember, you will be the public health officer for a compact little community, so your rôle is at least as much preventive as it is therapeutic.

If you do manage to visit the camp ahead of time—or, on your first day's duty, look around for possible sources of trouble. Make your tour of inspection with the head counselor or whoever is responsible for the physical plant of the camp and point out loose boards, holes in paths and grounds left by winter weather, even loose rocks on the baseball diamond. Hunt for insect nests along the wooded borders of the camp and have them destroyed before the campers arrive. I would guess that 99% of camp practice involves injury, infection, and bites—insect bites, of course. Eliminate as many sources of these difficulties as possible before the season opens, and you may find time for more fishing or tennis or carpentry than you had expected.

While you're around, pay a courtesy call on the local doctor and pharmacist. You probably won't have a chance for the first week or two after camp opens, and by then you may have more than one occasion to need their cooperation.

Mayhem and physicals

What happens when the children arrive and the job actually begins? Chances are that the first day or two will be mayhem, as campers and counselors settle in and begin to get into the spirit.

You will probably be busy all day as the kids come down cabin by cabin for their initial weighing-in. At the same time, you would do well to listen to heart and lungs, check ears, nose, and throat. Check the boys for hernia. Usually, all the children will have been examined by their family physicians before being accepted by the camp, but you can save yourself some headaches later on by checking up early.

You will probably be bombarded with notes, letters, and instructions for allergy injections: turn them all

over to your nurse and let her draw up a schedule and make a card index with a card for each kid, noting any individual peculiarities that should be especially watched for during the summer.

Trickle or schedule?

After the first couple of days, you will begin to see your first patients. You will have to suit yourself as to how you will see them, whether you will tie yourself and your nurse down by the trickle system, whereby kids just wander into the dispensary at their leisure all day long, or whether you will establish a set time or times for sick call, and handle only emergencies at other times. I used the second method and found that it worked like a charm. But this is a matter of individual choice.

Records and reports

Keep records of some sort. They needn't be elaborate or highly detailed, but nevertheless are an absolute necessity. A Kardex or similar system would be ideal, but an ordinary composition book can be used to record the camper's name, complaint, your diagnosis, and the treatment. The mechanics may become rather involved, since it is usually necessary to notify the counselor that a camper is to return for follow-up at a given time, that another one is a "no-swim" or "restricted activity," etc.

The head counselor and the camp office should get a twice-daily report of patients in the infirmary, admissions and discharges, and so on. Divide the responsibilities between yourself and the nurse and you will find that it can be a vacation for both of you, after all. In many camps, older campers are anxious to lend a hand and can be allowed to help with records, lists, messages and the like.

Therapy

The vast majority of your patients will have simple URI's. If they have no temperature, they don't have to be put in the infirmary, but should be kept out of the water and away from strenuous activities for a couple of days. Adjunctive therapy is up to you, but I didn't find any significant differences in recovery time between the kids who got nothing or just aspirin, and those who got one of the soluble sulfonamides for their sore throats. Use antibiotics for a definite indication—which means you won't be using them very often in a season, under normal circumstances.

An occasional child will be hypersensitive to the venom of a stinging insect and will turn up looking like a two-legged patch of urticaria. One experience like that taught me the value of 0.5 cc. of adrenalin (1:1000) and an I.M. antihistaminic agent!

What looks like acute appendicitis at midnight often looks like acute gastroenteritis in the morning, but don't take any chances. Do a WBC and differential (the nature cabin almost always has a microscope—don't take your own to camp) and get in touch with that good friend, the local doctor. If the child needs admission to the nearby hospital, he is the man to arrange it for you.

By and large, there is not likely to be anything coming up among 100 to 150 healthy youngsters that you can't take in stride. But it pays to smart and be humble. Ask for help if you need it.

Your vacation

Don't forget your most important responsibility—YOU! If you are like the average resident, you have been working pretty hard and selflessly during the year preceding your camp adventure. If you become a drudge and do nothing but minister to bee bites and running noses, and bury yourself in books in between, you're missing the whole point of being a camp physician. The usual camp is just loaded with facilities that most people have to spend a fortune for the privilege of using—boating, swimming, fishing, tennis, baseball, archery, riding, and a variety of arts and crafts shops such as woodworking, ceramics, leatherwork, painting, sculpture. Socially, too, most camps have a great deal to offer. The staff is usually young and friendly, mainly made up of teachers on vacation and college students who, like yourself, are trying to build up a tan and a bank balance at the same time. So, as kindred spirits, you will enjoy the company of your fellow staff members. One thing is almost certain to please you: you will find it infinitely refreshing to get away from talking medicine all the time.

Further social opportunities are sometimes available through nearby camps. Also, if there is a camp physician at a neighboring camp, you will be able to get together socially

and professionally.

Of course, in many areas of the country local attractions of extraordinary interest may be accessible from your camp site. But generally, you will depend on your own camp to provide you with opportunities for "summer socializing."

In addition to all this and in return for a good bit of hard work, you can finish up the season with a heavier pocketbook, a leaner frame and a broader mind.

"Physician, heal thyself"—and a summer camp is an ideal place to do it.

"But Mr. Lion, even so-called miracle drugs take time!"

By John F. Conlin, M.D.

Guest Editorial

THE RESIDENT, staff, trustees, and the hospital administrator have many things in common. Of these the major item is the united purpose to render to patients the best care which can possibly be produced.

There are many aspects of individual responsibilities of those associated in this common effort. Occasional misunderstandings arise. These should easily resolve if principles of community of effort toward ideal patient care remain the guide.

The residency should certainly be an educational experience. There should be no exploitation of the resident. His valued years of graduate training should not become a period of semi-compulsory, pre-professional peonage.

The trustees and the administrator have the responsibility of furnishing a favorable environment for this educational experience. Common creature comforts should meet standards higher than minimal. Housing, food, uniforms, financial

remuneration, recreational facilities, health programs, conference, library, and study facilities, supplies and equipment should receive adequate attention.

The staff, both full-time and part-time, has a major responsibility in furnishing organization and continuing administrative supervision to the educational experience. This calls for the assembly of the best medical minds of the community, dedicated men who lend their hearts, their brains, and their time to this serious contractual obligation.

John F. Conlin
M.D., M.P.H.
Director of Hospitals,
City of Boston;
Superintendent,
Boston City Hospital.

These will be fair-minded men. They will be understanding of the problems of individuals and of their varying degrees of ability. They will have a passionate interest in developing the brilliant practitioner, but they will be tolerant of capabilities which are slower to develop. An uncompromising attitude is needed toward weeding out the occasional incompetent.

The ideal training program will be directed by clinicians of outstanding ability. These will combine the necessary triad of interests in patient care, teaching and research. They will supervise with close attention the routine details of daily bedside care, of various diagnostic, surgical, and technical procedures. But more importantly, they will concentrate on the diagnostic clinic, on the accident floor, and on the problem patient where there is simply no substitute for top level skill and maturity of judgment.

The resident also has responsibilities. An individualist, he will adapt to the recognition of the compelling necessity for team-work. Beyond the traditional admonition to honor his preceptors he will be guided by the fact that what he gets out of his valuable years of resident training will be in proportion to the effort he makes.

We live in a changing order. Most of the early great

medical training centers were closely associated with the medieval City-States. Over the years the large voluntary hospitals emerged. The history of medicine is filled with the giants who practiced in these hospitals and who gave generously of their time to teaching in their charity wards.

More recently, with the growth and development of various third party payment plans, the voluntary hospitals have experienced a shift away from service patients toward private patients. This evolutionary process has been met in stride and good teaching programs have been maintained in many of these hospitals.

While these changes have been occurring, tax-supported hospitals have continued. The large municipal hospitals, their services generally directed by charter primarily for the care of the indigent, have usually been teaching hospitals, usually with university affiliation.

With an excess of internships and of residencies over available candidates to fill them, many hospitals have intensified their teaching programs. Some standards are set by the Joint Commission on Accreditation of Hospitals. Various American boards for the medical specialties keep close watch over the folds of their potential flocks.

It seems now that the role of the large tax-supported municipal general hospital is attaining even greater prominence in medical education. Tremendous out-patient departments, accident floors and receiving rooms busy around the clock, in-patients predominantly service cases—all demand well organized patient care, teaching, and research services of a high order. Where close cooperation with universities exists, and where clinicians with wisdom and vision are present in sufficient numbers and with adequate time, a powerful ferment is working. Add to these ingredients an adequate plant, equipment, supplies and budget and a forward-looking board of trustees, and it can be expected that an attractive and valuable residency training program will emerge.

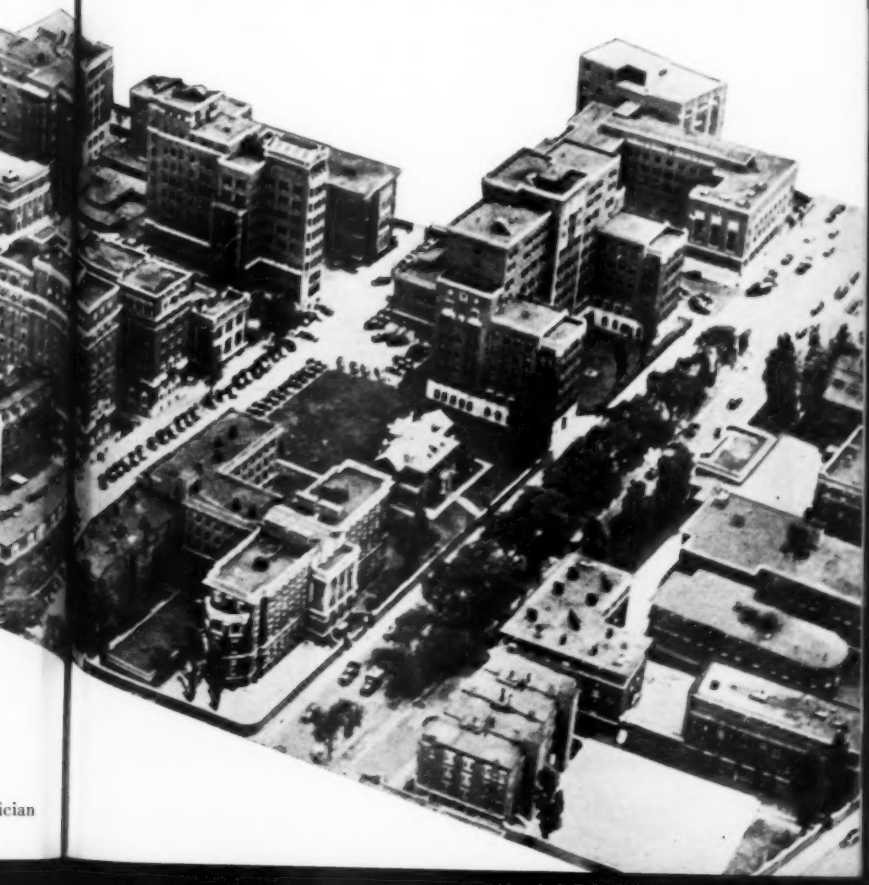
Boston City Hospital

Sixth of a series on resident centers

Boston City Hospital's physical plant consists of twenty-seven buildings which cover an area of two and a half city blocks. Most of the buildings are connected by tunnels.

Boston City Hospital is currently launched on the biggest construction program in its history. Plans stretching well into the next decade have charted a broad path of expansion which will improve the hospital plant, patient care, personnel training programs, house staff accommodations, research facilities—and just about everything else from plumbing to parking.

Even the neighborhood immediately surrounding Boston City



Hospital's two and a half square blocks of buildings is in for a radical face-lifting. Through gradual deterioration, the City Hospital vicinity had become an eyesore. But in the present reconstruction, side by side with plans for an integrated South End Medical Center, has come slum clearance. Considerable inroads have been made toward removing the substandard residential dwellings near the hospital. One housing project has already replaced a part of the slums; a second major housing development is under way. And a new arterial highway, now abuilding, will divert traffic, relieving the congestion near the hospital.

The rebuilding program at the hospital itself will involve millions of dollars for rehabilitation of existing structures, and additional millions for new buildings to be constructed from the ground up.

According to City's superintendent, John F. Conlin, M.D., "the present story of Boston City will probably read like a short course in bricklaying—but construction is one of our main concerns at the moment. Actually, this is a fairly accurate picture of where we are as of now."

Origins

As with most metropolitan hospitals, Boston City has had other periods of expansion. Though still located in the City's South End where the original hospital was opened in June, 1864 (on the site of an old

First used in 1869, these tent wards were set up on Boston City Hospital grounds in the summer, packed away in the winter. The photograph was taken in 1898, just after 200 Spanish American War vets, ill with typhoid and malaria, moved into the tents. More than 600 soldiers were treated in 1898, the last year tents were used.

race track), the present hospital has few architectural links with its past. Parts of but two of the original buildings still stand and are in use at the present time.

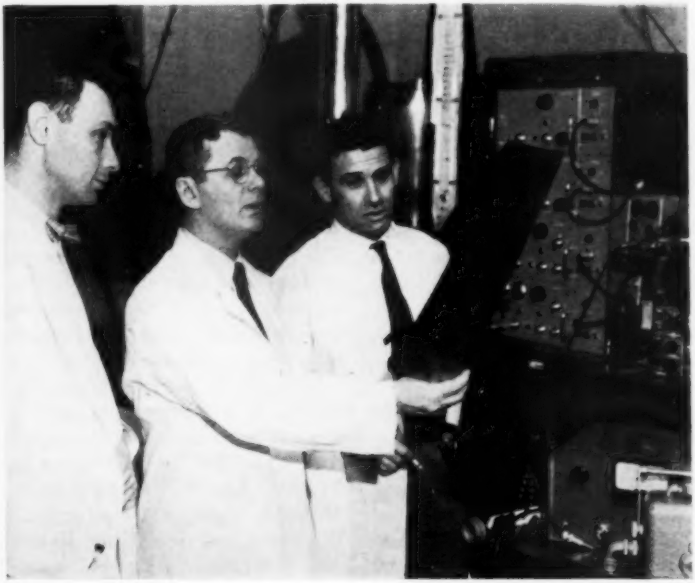
The last building program took place in the 1930's and early 1940's. From that time until the present program began, only necessary alterations and additions were made.

Big and busy

Boston City Hospital is a municipally operated general hospital with 1,716 beds, 115 bassinets. Last year, City recorded 34,798 admissions, nearly 365,000 outpatient visits, 14,180 operations (9,029 major), 2,513 deaths, 1,039 autopsies (41%).

Also in 1955, Boston City Hospital physicians assisted in 2,935 deliveries with Caesareans accounting for four percent of this total. (There was one maternal death in each of the years 1954 and 1955.) Nearly 110,000 diagnostic x-ray procedures were accomplished with 7,198 x-ray treatments in 1955.

Checking chest x-ray with recorded data at Boston City Hospital's inhalation therapy and lung station, Dr. Maurice S. Segal, director of the department, discusses the findings with residents Dr. Merril M. Goldstein (left) and Dr. Ernest O. Attinger.



Dr. Martha Lovell a junior resident in pediatrics, performs a subdural tap on a two-month-old infant at Boston City Hospital while Dr. Phyllis Hagerman supervises.

Medical neighbors

Next door to Boston City are the Boston University School of Medicine and the Massachusetts Memorial Hospitals. On the same street are Tufts University Medical School and the New England Center Hospital (RESIDENT PHYSICIAN, March, 1956). Harvard Medical School is within a fifteen minute drive.

separate teaching services in affiliation with Boston City Hospital. For example, the six medical services at City are divided, two each, among Boston University, Harvard and Tufts. Likewise, Boston City's surgical services, three in number, are conducted by the three medical schools.

Organization

The hospital is under the direction of a board of five men, trustees who serve without pay. One member is appointed each year by Boston's mayor for a term of five years.

The present superintendent, Dr. Conlin, is a relative newcomer to hospital administration. Appointed August 1, 1954, he also serves as Visiting Lecturer in Preventive Medicine, Tufts, and Instructor in Preventive Medicine, Boston University. Dr. James V. Sacchetti, assist-

ant superintendent, was Medical Director at Long Island Hospital, Boston, until 1951, and superintendent at William J. Seymour Hospital, Eloise, Michigan, until he came to Boston City on September 1, 1954. There are nine physician-executive assistants.

There are 500 physicians on the visiting staff; nearly all are members of the teaching staffs of Boston University, Harvard or Tufts Medical Schools. There are 57 salaried physicians above the rank of chief resident, most of whom are full time and whose duties include patient care, teaching and research.

House staff—stipends

In addition to the usual clinical clerks there are 10 fourth year medical student "sub-juniors" who live in. There are 78 interns and 239 residents. Annual pay for various grades ranges from $1,104 for interns, $1,344 for junior assistant residents, $1,584 for senior assistant residents, $1,944 for residents, $2,424 for chief residents or teaching residents to $3,000 for fellows.

Straight internships

I & III Medical, Tufts	16
II & IV Medical, Harvard	16
V & VI Medical, Boston University	16
I Surgical, Tufts	8
III Surgical, Boston University	8
V Surgical, Harvard	8
Pediatrics, Boston University	4
Pathology	5

Current residencies

One year appointments are offered as follows:

Three Medical Units	
Jr. Asst. Residents	24
Sr. Asst. Residents	18
Residents	6
Three Surgical Services	
Jr. Asst. Residents	24
Sr. Asst. Residents	15
Residents	15
Chief Residents	3
Teaching Residents	3
Pathology	
Jr. Asst. Residents	3
Sr. Asst. Residents	2
Residents	2
Senior Residents	2
Pediatrics	
Asst. Residents	10
Residents	2
Obstetrics–Gynecology	
Jr. Asst. Residents	9
Sr. Asst. Residents	5
Residents	4

There are additional residencies in anesthesiology, dermatology, neurology, neurosurgery, ophthalmology, oral surgery, otorhinolaryngology, pediatric surgery, physical medicine and rehabilitation, radiology, thoracic surgery, and urology. Others are in planning.

Appointments

House staff appointments are made by the trustees on nomination by the administrative heads of the services with the concurrence of the Coordinator of Teaching, Dr. John P. Rattigan.

Residents and interns are not permitted outside activities for compensation. Uniforms, meals, laundry and quarters with maid service are furnished. There is a vacation allowance. Medical care is supplied. The house officers' lounge has recently been redecorated and is being refurnished and plans have been completed for extensive alterations to the house officers' dining room. Female resident and intern quarters are also being extensively altered.

There are Catholic, Jewish and Protestant Chapels located within the hospital with full-time chaplains of the major religious groups and visiting chaplains from the others.

Exchange residency programs are conducted with a limited number of hospitals. Occasionally, a leave of absence is permitted for accredited special training.

Problems

According to the hospital's administrators, existing house staff quarters are overcrowded. No housing is furnished for those who are married. "Both these problems urgently need solution. The neighborhood eating places leave much to be desired except for a Howard Johnson's a quarter mile removed. Parking areas are grossly inadequate. These are being enlarged but will still be far from satisfactory. Hit and run collision damage, vandalism, police tagging and towing from adjacent streets make the lot of the car owner an unhappy one."

Teaching rounds

There are daily teaching and ward rounds on the services with full-time clinical teachers supervising. There are weekly grand rounds, service and combined service amphitheater conferences and clinics. There are death meetings, pathology conferences, clinical-pathological conferences, rounds with consultants, combined conferences with the special services, with members of the Departments of Pathology and Radiology frequently presenting special material and contributing to the discussions.

Held at the hospital are local medical meetings to which all physicians are invited. Various local specialty groups are welcome to use the hospital amphitheaters, increasing house staff educational opportunities.

The House Officers Association plans and produces a splendid and well-received series of evening lectures every second week, October through May. Outstanding physicians and scientists from various parts of the United States and abroad have participated. Stipends are paid by the hospital.

Recreation

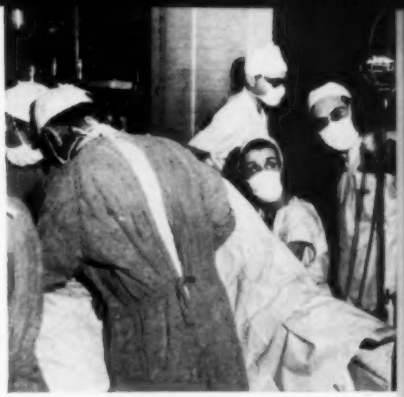
In the building housing the house staff is a swimming pool and squash court for off duty recreation. Free golf privileges are available on a city-owned golf course. Tennis courts are located on the hospital grounds — but these may soon give way to construction of the new nurses' residence. (Traditional "change parties,"

according to the administration, "have become somewhat less ebullient than in years past.")

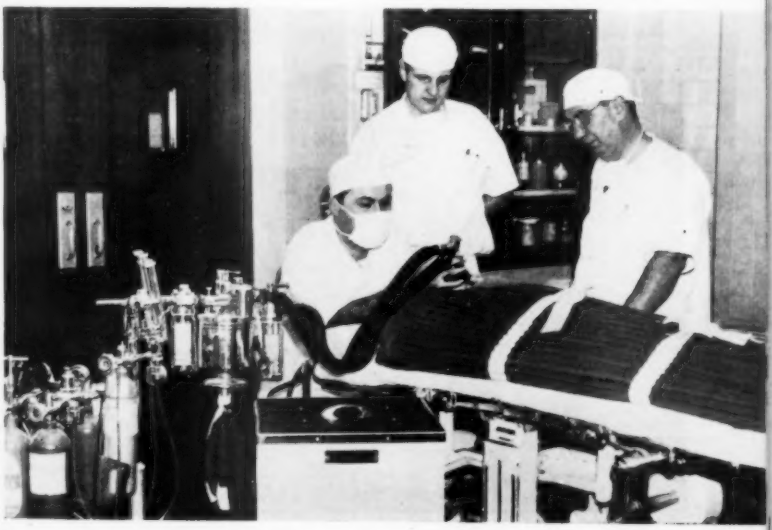
Outside entertainment and recreation facilities in the Boston area include many cultural, historical, scientific and sports attractions easily accessible from hospital properties.

Library

The hospital's medical library contains 11,000 volumes and nearly 150 current journals. There are also departmental libraries. The medical school libraries and various specialized sources are available. The hospital is an Institutional Member of the excellent Boston Medical Library. Residents and interns are encouraged to present, discuss, speak and write. Individual project and



Dr. Caesar Ramon (above), anesthesiology resident, adjusts flow of relaxant, instructs student nurse anesthestist during appendectomy. Below, Dr. Kirkor Sekercan and Dr. Arthur Ogden anesthetize a patient with a hypothermic mattress under direction of Dr. Phillip S. Marcus, chief anesthesiologist. Latest anesthetic methods are taught at City.



Radiology residents, Dr. Jean A. Vezzina and Dr. Ambrose Finnell discuss microfilmed case histories. Below: Boston City residents, Drs. Carl Tisch, G. E. Sinclair and Paul Binette inspect sterilized surgical packages. Miss Eleanor M. Kearney, R.N., Supervisor of the hospital's central supply department, explains distribution.

record studies and research activities are stimulated.

Efforts are under way toward work simplication procedures. All traditional procedures are under review. Additional service laboratories and technicians have been supplied wherever possible. Increased use is being made of ward clerks and service secretaries. Additional record room assistance has been supplied. Runners are provided wherever possible to reduce time wastage of valuable professional personnel.

Hospital Department

Two years ago a reorganization plan was effected which created the city's Hospital Department. To Boston City Hospital with its South Department contagious disease unit and the East Boston Relief Station was added the Boston Sanatorium. With 590 pulmonary tuberculosis beds, this institution is the Commonwealth's largest T.B. facility. The Long Island Hospital was also added. Long Island with 775 hospital beds and dormitory facilities for 439 patients, is now the chronic disease unit of the Hospital Department.

Maternity

A separate maternity building houses Ob-Gyn patients, delivery rooms and newborn and premature nurseries. Construction is about to start on a new premature nursery unit. A new caesarean section operating room and other delivery floor alterations will soon be under way. A large fully-equipped, air-conditioned Central Sterile Supply Service has recently been completed in the basement of this building. Work is about to be started on a new conference room having a capacity of 100 persons.

Surgical facilities

The surgical building houses some general surgical patients and the orthopedic and urological services. The Thorndike building contains the Thorndike Memorial Laboratory, Thorndike Amphitheater facilities for medical research and clinical investigation as well as in-patient facilities. The Thorndike staff is under the direction of Drs. William Castle and Max Finland.

The Thorndike building first floor, basement, and an adjoining wing, house the main x-ray diagnostic and therapy units. The Tumor Clinic is also located here.

The Mallory building contains the Mallory Pathological Institute, Mallory Amphitheater, morgue, autopsy rooms, general pathology, neuropathology and other special study facilities including extensive bacteriological, tissue preparation, and pregnancy test areas. Boston City Hospital Pathology Department is directed by Dr. G. Kenneth Mallory.

Sears unit

The building formerly known as the "old surgical building" which houses the Cheever Amphitheater is now the Sears Surgical Laboratory. This

unit resulted from the bequest of the late Charles H. Tyler. Dr. J. Engelbert Dunphy joined the hospital staff in July, 1955, as Director of the Sears Unit. Reconstruction of the building is partially completed.

The Sears building also houses the nurses infirmary, a diabetes and metabolic diseases unit, the Department of Inhalation Therapy, Dr. Maurice S. Segal, Director; The Circulation Laboratory, Dr. James W. Dow, Director; Anti-coagulant Laboratory, Dr. Herbert S. Sise, Director; the Nursing Arts teaching ward; a teaching program on Human Ecology (a Commonwealth Fund study on pregnant patients in their third trimester), Dr. Henry J. Bakst, Director; the Gastroenterology Unit and the Biochemistry Laboratory (temporary).

Nurses

There are four separate buildings housing nurses. The universal nurse shortage is particularly acute at Boston City Hospital and the enlargement of the nurse training school facilities with intensified nurse recruitment is one of the most urgent present problems. A 500-room nurses home has been announced as a planned project. Such construction would free additional space for the resident staff.

New laboratories

The Medical Building contains (along with two other buildings) the major medical services, neurology and neurosurgery. Badly needed new biochemistry laboratories are being constructed in the basement area.

The Burnham building, in addition to medical patients, houses the Heart Station. The latter unit is overcrowded and plans are being made for expansion.

The Pediatrics Building houses Pediatric and Pediatric Surgery services. A new Milk Formula Laboratory will be built shortly, and a new laboratory for the Pediatric service is planned.

New laboratories and conference rooms for the Fifth and Sixth Medical Services (Boston University) have been recently completed in the Pavilion Building. Equipment is being installed. The unit is in partial operation.

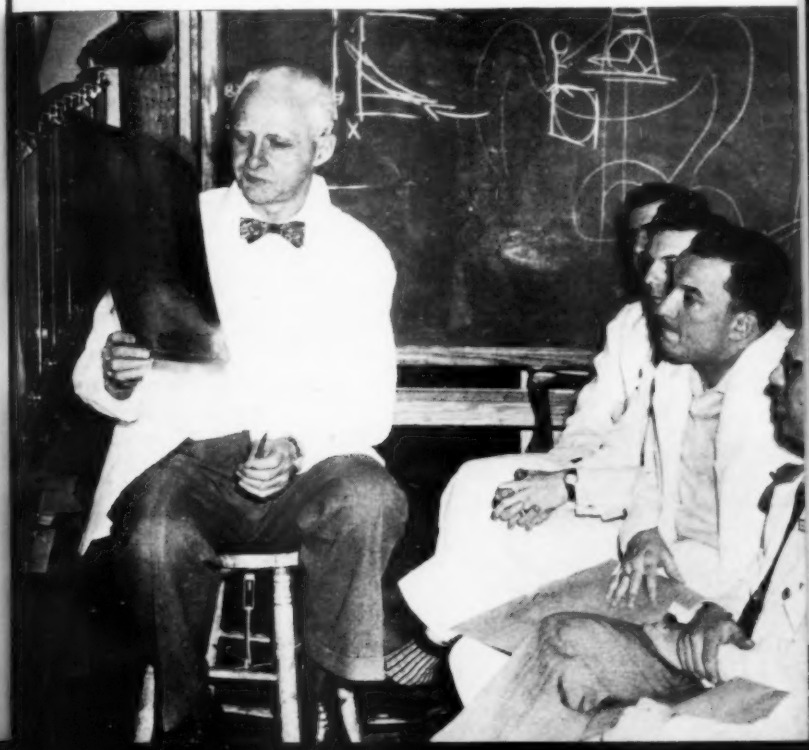
The Dowling building contains the admitting department, accident floor, operating rooms, recovery area, blood bank, Fenwal laboratory, admitting chest x-ray unit, nearly 500 surgical beds and the Dowling amphitheater. It is the newest of the hospital's buildings. The Shortell fracture unit, located in a wing added to this building was opened four years ago. The unit has already outgrown its capacity. In a recent month more than 5,000 patients were handled by this unit and more than 8,000 x-rays taken.

Funds are available and plans are in preparation for extensive alterations in the Dowling Building. Addi-

tional operating rooms are needed. Present operating facilities are to be re-designed and re-equipped. Additional elevator capacity is needed. An observation ward unit is planned. Construction of a new ambulance entrance will be started shortly.

In South Department, the contagious disease unit, there were 250 polio patients cared for during last summer's outbreak. About 80 male tuberculosis cases are under treatment and a residue of 35 polio patients, many of whom are long term treatment problems, remain. These facilities will be expanded.

Residents sharpen their diagnostic skill at x-ray teaching conference conducted by Dr. Max Ritvo, director of radiology and chief Roentgenologist at City. At conferences, only one physician has been given the diagnosis ahead of time.



Other construction

● Planning is nearly complete for a central low pressure oxygen system for the entire hospital.

● A two floor wing addition to the administration building has just been authorized and funds have been made available.

● The addition of a new wing to the x-ray department is planned for the near future.

● The Dermatology service, Dr. Bernard Appel, Physician-in-Chief, has instituted a new graduate training program leading to an advanced degree. Wards for this service are in planning and the work is to be expedited.

● Wards for the treatment of alcoholics, psychiatric patients, and for narcotic addiction treatment are now being planned.

● A new Diabetes laboratory is being designed.

● A new Gastroenterology unit is being constructed.

● Conference rooms and laboratories are currently under construction for the First and Third Medical (Tufts) services.

● Physiotherapy and rehabilitation facilities are being enlarged.

● A record carrier system is being installed.

● Reproduction equipment is being expanded to improve communication.

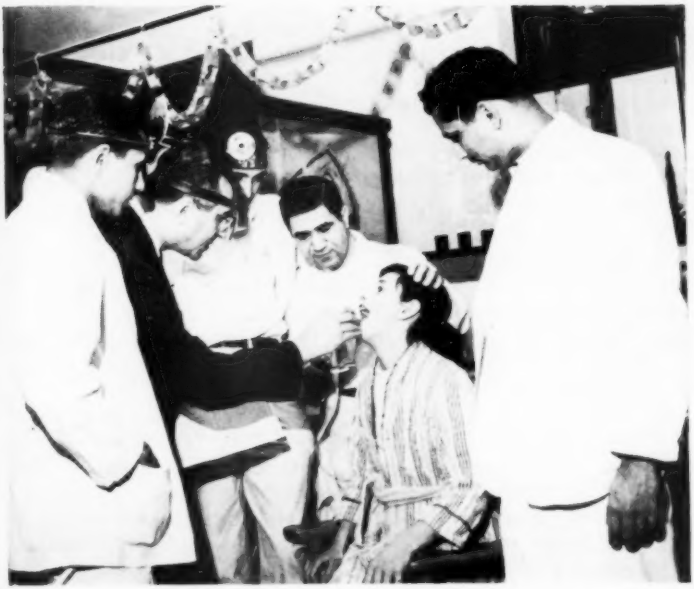
● An Audio-Visual unit is being set up to improve facilities for instruction, including patient and outpatient education.

Alumni

Boston City Hospital has had a distinguished past in service and education. Dr. Conlin states: "The years have seen the coming of Mallory in pathology, David W. Cheever in surgery, Francis H. Williams in radiology, George H. M. Rowe in administration, Cotton in orthopedics, Timothy Leary in pathology, Minot in medicine, Lahey in surgery, Soma Weiss in medicine and others. There are 3,000 alumni of Boston City Hospital in all parts of the world . . . deans, professors, brilliant clinicians and researchers.

An incident concerning an alumnus of City hospital was mentioned recently in this journal. ("What's the Doctor's Name?" *Resident Physician*, January, 1956.) Many years ago, one of Boston City's interns was making his departure. The superintendent remarked: 'There goes a young man who will never come to any good.' The departing intern was Leonard Wood who went on to attain fame in medicine and as a military leader.

The Boston City Hospital Alumni Association saw fit some years age to "take issue with the superintendent's judgment," reports City's present superintendent, Dr. Conlin. "The Leonard Wood Medal is now awarded annually to a distinguished alumnus of the hospital by the Association in recognition of his contributions to medicine and to humanity." Among Leonard Wood Medal recipients have been George



Foreign residents watch Dr. A. J. Gorney, ENT Chief, examine patient. *L to R:* Drs. A. Kenter (Turkey), M. Baptista (Portugal); R. Shankar and Y. Kapur (India).

Minot, Elliott Joslin, David Scannell, Shields Warren, Chester Keefer, William Castle, Otto Hermann and Frank Lahey. In Dr. Conlin's words, "May their tribe increase!"

Administrative heads

The directors of Boston City's services and laboratories are as follows:

First and Third (Tufts) Medical —Fernando Biguria, M.D., Director. (Clinical Professor of Medicine, Tufts)

Second and Fourth (Harvard) Medical — William B. Castle, M.D., Director, Thorndike Memorial Lab. (Professor of Medicine, Harvard)

Fifth and Sixth (Boston University) Medical — Kermit H. Katz, M.D., Director. (Associate Professor of Medicine, Boston University)

Dermatology — Bernard Appel, M.D., Physician-in-Chief. (Professor and Chairman, Department of Dermatology and Syphilology, Tufts)

Pediatrics — Charles V. Pryles, M.D., Assisting Physician. (Acting Physician-in-Chief and Director of Teaching)

First (Tufts) Surgical — Charles G. Child, 3d, M.D., Director; and Director First (Tufts) Surgical Laboratory. (Professor of Surgery, Tufts)

Third (Boston University) Surgical — John J. Byrne, M.D., Director; and Director Third (Boston University) Surgical Laboratory. (Associate Professor of Surgery, Boston University)

Fifth (Harvard) Surgical — J. Engelbert Dunphy, M.D., Director; and Director, Sears Surgical Laboratory. (Professor of Surgery, Harvard)

Orthopedic Surgery — Alexander P. Aitken, M.D., Surgeon-in-Chief, Director of Fracture and Orthopedic Service. (Professor of Orthopedic Surgery, Tufts)

Pediatric Surgery — John W. Chamberlin, M.D., Surgeon-in-Chief. (Assistant Professor of Surgery, Boston University)

Thoracic Surgery — John W. Strieder, M.D., Surgeon-in-Chief. (Professor of Clinical Surgery, Boston University)

Urology — Frank G. Sheddan, Jr., M.D., Surgeon-in-Chief. (Assistant Professor of Clinical Urology, Boston University; Instructor in Surgery, Harvard)

Anesthesiology — Phillip S. Marcus, M.D., Director. (Assistant Professor of Anesthesiology, Tufts; Assistant Professor of Clinical Anesthesiology, Boston University)

Gynecology and Obstetrics — Benjamin Tenney, Jr., M.D., Director. (Professor of Obstetrics and Gynecology, Boston University)

Neurology — Derek E. Denny-Brown, M.D., Physician-in-Chief; Director, Neurological Unit. (Putnam Professor of Neurology, Harvard)

Neurosurgery — Walter Wegner, M.D., Surgeon-in-Chief. (Associate in Surgery, Harvard)

Physical Medicine and Rehabilitation — Jacob L. Rudd, M.D., Physician-in-Chief

Ophthalmology — D. Robert Alpert, M.D., Visiting Surgeon (Acting Surgeon-in-Chief)

Otorhinolaryngology — Arthur J. Gorney, M.D., Surgeon-in-Chief. (Assistant Clinical Professor of Otolaryngology, Tufts)

Oral Surgery in Department of Dentistry — Austin T. Williams, D.M.D., Visiting Surgeon (Acting Surgeon-in-Chief; Acting Director, Department of Dentistry)

Pathology — G. Kenneth Mallory, M.D., Pathologist-in-Chief; Director, Mallory Institute of Pathology. (Professor of Pathology, Boston University; Lecturer on Pathology, Harvard)

Radiology—Max Ritvo, M.D., Director. (Assistant Clinical Professor of Radiology, Harvard; Instructor, Tufts)

Biochemistry Laboratories—F.H.L. Taylor, Ph. D., Director. (Associate in Research Medicine, Harvard Medical)

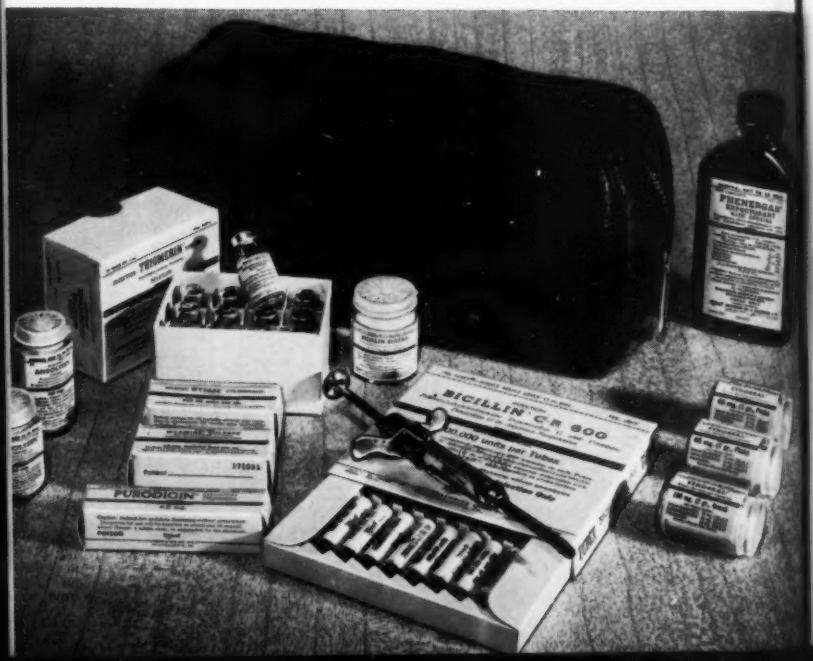
Clinical Laboratories — William C. Moloney, M.D., Director. (Clinical Professor of Medicine, Tufts)

A brochure containing further information on residencies at Boston City Hospital may be obtained by writing to: Chairman, House Officer Committee, Boston City Hospital, Boston 18, Mass.

OUR THANKS to Dr. John F. Conlin, Superintendent, Boston City Hospital, for his cooperation in the preparation of the material on Boston City and to Robert Gur-Arie, (Public Relations); and Patrick Pergola (Audio-Visual Department) for the photographs published with the story.

"I still say it's Lupus Erythematosus!"

How Wyeth Welcomes the New Physician



No day in the medical career is more memorable than the first day of practice. For every Intern and Resident reaching this milestone, Wyeth Laboratories has a Welcome-to-Practice Service.

If you plan to enter practice before the end of 1956, see your Wyeth representative or write to us telling of your plans and we shall have your Wyeth representative stop to see you. He will be happy to provide certificates that will make you eligible for the program.

Leather Utility Bag with Basic Medications: Illustrated here, this useful kit contains a variety of products that the new physician will wish to have for his day-to-day practice.

Name Plate: Practice starts with the name on the door. Wyeth helps here, too, with a name plate of quiet dignity. A plastic stand is also available for those who prefer the name on the office desk.

S-M-A®: Through its Physician's Family Service Plan, Wyeth supplies S-M-A for the nutrition of the physician's baby. When you open practice, remember S-M-A—without cost—for that newcomer of your own.

And there are many other services available to fit your individual practice that your Wyeth representative will review with you.

When will you enter practice? Be sure your Wyeth representative knows. There's an annual Wyeth program timed to meet the needs of every new physician.

Wyeth

Clinico–Pathological Conference

Boston City Hospital, Boston, Mass.

History

This was the first Boston City Hospital admission of J. K., a 38-year-old housewife, who entered with the chief complaint of back pain. She had apparently been well until eight months prior to admission when she had noted the onset of brief episodes of diffuse backache, relieved by rest and aspirin. There had been no trauma and she denied other musculo-skeletal symptoms The pain had become constant during the week before entry and she had been confined to bed for the first time. During this week she had had two syncopal attacks on attempting to rise from bed; there had been no convulsive movements or incontinence. For two days she had felt feverish and weak; during the night before entry she experienced a severe frontal headache accompanied by nausea and the vomiting of clear liquid. The patient had had a nonproductive cough for one year; there had been no night sweats, chills or fever. She had, however, lost 14 pounds in weight. Past history and review of systems was otherwise negative. While the patient admitted to only a modest alcoholic intake, her husband stated that she had been a heavy drinker for many years.

Examination

Physical examination revealed a somewhat uncooperative white female sitting up in bed in no distress. The patient was disoriented in time, thinking this to be her second hospital day. The temperature was 101.8°; pulse 112; respirations 32; blood pressure 130/60. The skin was warm and dry; the sclerae were icteric. Examination of the chest was not remarkable. The heart sounds were distant; there was a grade II blowing systolic murmur in the third left interspace. A slight-

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Case presented from the Second and Fourth (Harvard) Medical Services, Boston City Hospital.

ly tender liver edge could be felt four finger breadths below the right costal margin. There was minimal bilateral costovertebral angle tenderness. A yellowish vaginal discharge was present. Neurological examination was negative except for an equivocal extensor plantar response on the left.

The admission urine was cloudy yellow; pH 6.5; specific gravity 1.003. There was no sugar, bile or acetone. The centrifuged urinary sediment contained 2-3 red cells and occasional clumps of white cells; many gram negative rods were present on smear. The hematocrit was 44%; WBC 10,000 with 69% polymorphonuclears and 31% lymphocytes. The Hinton was negative. Stool guaiacs were negative. Blood chemistries: BUN 8 mg%; NPN 27 mg%; chloride 86 mEq/L.; CO_2 47 vol.%; FBS 96 mg%. Urinary diastase was 400 units; on the third hospital day it was 600 units. Liver function studies were as follows: serum bilirubin 4.0 mg%; cephalin flocculation 4 plus; formol gel 4 plus; total protein 6.2 Gm%; prothrombin time 17 sec. (control 13 sec.); urine urobilinogen 1:16. Blood cultures yielded no growth; urine culture revealed E. coli; cervical culture, E. coli and gamma strep. Lumbar puncture revealed clear fluid under normal pressure; the Pandy was negative. The total protein was 15 mg% and there were two lymphocytes. Chest x-ray and films of the lumbar spine were normal. An abdominal film confirmed the enlarged liver.

Course

During the first three days of hospitalization, her temperature ranged between 100° and 103°. A repeat WBC was 9,000 and the sedimentation rate was 42 mm. Bile was now present in the urine. On the 4th day the patient's left pupil appeared larger than the right; an extensor plantar response was definitely present on the left. Repeat lumbar puncture was again entirely normal. A liver biopsy performed at this time was reported as "fatty nutritional cirrhosis with bile stasis." I.V. tetracycline was begun on the 5th hospital day. The temperature rose to 104° on the 7th day; the respirations continued rapid and the patient was now semi-stuporous. New findings included marked right CVA tenderness and nuchal rigidity. The neurological examination was negative except for the left Babinski. The WBC was 7,900 with 47% poly's and 53% lymphocytes. I.V. tetracycline was discontinued and aureomycin, streptomycin and isoniazid were begun. Her temperature rose to 105° on the 8th day; she became more stuporous and expired quietly.

Discussion

Dr. Norman Zamcheck:* The prob-

* Associate Visiting Physician, Boston City Hospital.

lem we have here is to decide whether this patient had a single disease or several diseases to explain the multiple organ involvement and rapidly fatal course. I shall say at the outset that I believe miliary tuberculosis is the most likely diagnosis; it is well-known that alcoholic patients, especially those with liver disease, have a high susceptibility to tuberculosis. There is no doubt that this patient has liver disease. The history of alcoholism and the jaundice, abnormal liver function studies and liver biopsy establish the diagnosis of fatty nutritional cirrhosis. This cannot, however, explain the entire clinical picture. Rapidly fatal liver disease on an alcoholic or nutritional basis is occasionally associated with abundant necrosis of liver cells and the term "acute alcoholic hepatitis" is sometimes applied to this condition. In the majority of cases, however, the white count is elevated above 10,000 and there is a significant polymorphonuclear response. Patients with cirrhosis who die without clear explanation may have a superimposed hepatoma. This woman is relatively young, however, and has too short a history of liver disease to support this diagnosis. One might relate the cerebral manifestations to a metastasis from a malignancy of the liver or pancreas, but I consider this far-fetched. Miliary tuberculosis almost invariably involves the liver and I am disappointed that the liver biopsy did not show ganulomata. Although liver biopsy is usually quite successful in the diagnosis of tuberculosis of the liver, it may miss primary or secondary neoplasms in a significant percentage of the cases.

The pathological description of bile stasis suggests the possibility of biliary tract disease; bile stasis may occur in small quantity in fatty nutritional cirrhosis or in larger amounts in extra-hepatic obstruction and cholangiolitic hepatitis. Obstruction may be on the basis of pancreatic disease, inflammatory or malignant, or common bile duct obstruction by stone or neoplasm. An 8 month history of back pain in an alcoholic patient raises the possibility of pancreatitis, and the 14 pound weight loss and elevated diastase would support this diagnosis. Left CVA pain is not uncommon in pancreatitis but pain on the right is unusual; I would feel this suggests a right perinephric lesion rather than pancreatitis. The occasional rbc's in the urine are consistent with this. Although I do not believe that this patient has acute pancreatitis or severe chronic pancreatitis, I will not be surprised if the pathologist shows us some evidence of a mild inflammation of the pancreas. I do not believe the evidence for bile stasis was enough to suggest the other diagnoses of biliary obstruction.

This patient died in coma. Is this hepatic coma? In hepatic coma one may see an extensor plantar response and abnormalities of the

pupils. The rigidity of the muscles seen in hepatic coma is a generalized phenomenon and not localized to the neck muscles. The neck rigidity alone is suggestive of meningeal irritation. No "liver flap" was described and I think this is further evidence against the diagnosis of typical hepatic coma. If this is not hepatic coma, what did cause her central nervous system disturbance? We are given the history of two syncopal attacks, severe headache, nausea, vomiting and the finding of an extensor plantar response and nuchal rigidity. The house physicians were apparently concerned about the possibility of meningeal disease since they did two spinal taps; both of these were negative. Early in the course of rapidly fatal miliary tuberculosis, however, one may have entirely negative spinal fluid even when the process involves the meninges. I should have expected the spinal fluid sugar and chlorides to be low, but unfortunately these tests were not done. The chest x-ray does not reveal any miliary lesions but this, of course, does not rule out the diagnosis. One might also have considered the possibility of tuberculous pericarditis but here also the x-ray studies fail to support this diagnosis.

In any case of fever of unknown origin one must consider the diagnosis of subacute bacterial endocarditis. It would be interesting to explain the syncopal episodes on the basis of cerebral emboli and the rbc's in the urine as the result of emboli to the kidneys. We have no additional evidence to support this diagnosis, however.

In conclusion, I feel certain that this patient did not die of her liver disease and, to my mind, miliary tuberculosis provides the best explanation for her demise. My diagnoses are, therefore: 1. Miliary tuberculosis, and 2, Fatty nutritional cirrhosis.

Pathological Diagnoses

1. Miliary tuberculosis of lungs, spleen, liver, adrenal, bone marrow and kidney.

2. Fatty nutritional cirrhosis.

3. Pulmonary congestion and edema.

Permission to examine the brain and spinal cord was not obtained.

Edited by Norman J. Selverstone, M.D., Assisting Physician, Boston City Hospital.

Orthopedic Board Exams

Final date for filing applications for the Orthopedic Surgery Board's Part II examinations to be given in January, 1957, in Chicago, is August 15th, 1956.

For information write: Dr. Sam W. Banks, Secretary, 116 South Michigan Avenue, Chicago 3, Illinois.

"Help These People . . ."

Because of her father's wish—and her own childhood dream—this Chinese girl began to study medicine. And though she tells of her journey toward medical education with matter-of-fact simplicity, the reader will see between the lines, a story of incredible courage and determination

Stella Yen, M.D.

I was born in the old historical city of Peking, twenty-six years ago. I suppose it can be considered an uneventful childbirth; my mother carried me to term, suffered no toxemia, and the labor evidently was not prolonged; I crawled forth via NSD and cried spontaneously.

But because it occurred on the fifth day of February by the Chinese calendar, there was quite a stir in the household. According to the Chinese, any child born on that day is destined to suffer.

My parents, however, had received a thorough Western education; they were not worried. And as if to banish any unpleasant possibilities, they named me "Stella," meaning star.

Convent school

From the school they sent me to, I don't think my parents ever dreamed of my becoming a doctor. At the Convent of the Sacred Heart, I was taught French, music and most especially, to be a refined young lady. (By nature, I was quite a tomboy.)

My health was very poor during the early years of my life. I had cholera, typhoid fever and bouts of chorea. During these spells of sickness I had frequent contact with doctors of all kinds. I never thought too much about them or what they did, though—and, I hated hospitals.

Beginning of a dream

No one ever accused me of being a "bright" child. Far from it. I was also very clumsy, often dropping things when my hands went into tremor. Yet, I managed to get high grades in school which pleased my parents very much and confused nearly everyone else.

As a child in her native China, Stella Yen once dreamed a big, improbable dream. "Someday," she thought, "I will go to the United States and learn medicine." Dr. Yen's dream, strengthened by her father's wish, has become a reality. Today, as an exchange student, Dr. Yen is a resident in obstetrics at Good Samaritan Hospital, Dayton, Ohio.

Learning on the run, Dr. Yen survived two civil wars, World War II, and "worst of all," the Communist invasion of China.

"My father and two brothers were killed by the Communists," she wrote. "Only my mother still lives —she is under arrest."

Dr. Yen believes she would face certain death if she were to return to China now. Yet, her hope is to return someday to her people. "When the war is over," she says, "I can go back, well-trained." Recently, Representative William E. Hess of Ohio, introduced a bill in Congress to allow Dr. Yen to remain in the United States until it is safe for her to go home again.

"I wonder," she says at one point in her narrative, "how many Americans realize how lucky they are."

War seemed always to be going on. We were often forced to leave our home in the city and hide in the country. The worst came when the Japanese invaded China. We lived for a whole year in disguise, constantly moving from one place to another. And it was during this gypsy period that my dream of becoming a doctor took root.

An epidemic was going on in one of the towns we passed through and my little brother was one of many hundreds taken ill. There was no doctor, not even a nurse in the town or its vicinity. So we just sat around my brother—and prayed.

It is an experience of agony to watch a beloved one die and not be able to do anything.

His little chest was emphysematous, his color cyanotic. One thought kept running in my mind: if one could only make an opening through his chest.

My brother died; and in our grief I heard my father blaming himself for not reading enough medical books in his leisure time. "He would not have died, if we had a doctor," he said.

Father's wish

"Misfortune never comes singly," as the Chinese proverb goes. Shortly after my brother's death, my father developed a bowel obstruction and thinking he might die without surgical intervention (the nearest town with a hospital was four days journey on horseback), he called us to his bedside and left his will.

"One of you must study medicine and come out here to help these people." I smiled at him hopefully. He nodded his consent.

That night I did not sleep. I made a bargain with the good Lord and my prayer was answered; with a

Chinese herb, father began to get well. In no time he was fully recovered.

We two began to make plans, though I was not yet in high school. Father was very ambitious and always wanted the best. He talked to me about the big schools in America, said that he would send me to the U.S. for college. My mother was not of the same accord. She didn't think my health was good enough to take up the study of medicine. But she didn't protest strongly, taking my idea of being a doctor as the dream of a child which would soon be forgotten.

Permission granted

One evening a few years later, we were entertaining a Bishop at dinner. He spoke to us of the difficulty he had in keeping a doctor in his small mission hospital. He said, too, that he was having trouble in persuading female patients to be examined by male doctors. I spoke up: "You can count on me some day as your doctor." My mother couldn't believe her ears. Her daughter's dream had not been forgotten.

That night she came to my room and agreed to let me study medicine. But she would not consent to my leaving home for study in the United States. Peking Medical Union College was good enough, she said. "But later on you may go abroad for graduate studies if you so desire."

My father still wanted his daughter to have her medical education in the U. S. but finally gave in to mother's request. So did I.

For a while, thinking of Peking as my future school, I would stop my bicycle whenever I passed by, look in and smile to myself.

But when the time came for me to go to college, I chose Aurora University in Shanghai, for in the meantime I had embraced the Catholic faith and wanted to go to a Catholic medical school.

Aurora

Aurora was conducted by the French Jesuits under the French system. The medical school consisted of six years, no division of pre-medical and medicine proper, and our studies were all in French. (The students were of all nationalities.) Prior to admission, one year of French was required of those who didn't already know the language. When I went for my interview, the rector asked, "Parlez-vous Français?" With the familiar accent of a convent taught student, I answered immediately, "Oui, Mon Père." The fact that I was from a French convent led him to believe I knew French well enough. Heaven only knows the trouble I had with this language. The French I had learned as a little girl was passable in ordinary conversation, but certainly not in scientific studies. I struggled day and night.

Aurora was conducted in the very

essence of the word "strict." Two failures meant out. There was no such thing as repeating another year.

The worst, I think, was the oral examinations at the end of each semester. Standing in front of the board of examiners, you are given a topic to discuss. You must speak rapidly and in perfect French. Many failed. I used to call on all the Saints in Heaven while waiting outside the door to be called.

War again

In my second year, war was again threatening; students could no longer study peacefully. Several universities went on strike; the Communist students became very active. Aurora, however, carried on unperturbed and under the same regime. We had no time for politics.

Near the end of the semester, Peking was taken over by the Communists. Almost before we knew it they were approaching Nanking. Shanghai went into tumult. People rushed around, all in a hurry to get out before it was too late.

With the Communist seizure of Peking I had been completely cut off from home.

An aunt who was living in Shanghai, decided to send me out at the first opportunity. Then I received word of home: My father and brothers were dead, killed by Communists. My mother was under arrest.

Gaining passage on the Chinese National Air Line, I left Shanghai for Hong Kong, haven for refugees.

Hong Kong and Canton

Hong Kong has one medical school, the University of Hong Kong. They did not, however, take refugee students. To be admitted, one must have a British certificate after graduating from a school recognized by the British Government. After considerable negotiation, I was allowed to attend classes as an auditor.

Then, I heard that Lin-Nam University in Canton, which was still in the hands of Chinese Nationalists, was opening her doors to refugee students. Lin-Nam was a mission school and well known for its medicine. The studies were in English. I took the train to Canton and was enrolled. But in two months the Communists were near Canton. I returned to Hong Kong, realizing at this time that there was no chance for me in China. The Communists now had taken hold of the entire country. In order to continue my medical studies, I would have to go abroad. First I applied to several schools in this country but I was unable to secure a visa. The only opportunity open to me was at the University of Santo Tomas in Manila.

Santo Tomas

Santo Tomas has a tremendous number of medical students, our class numbering more than 700. Half of these were girls. We used U. S.

textbooks and the studies were in English, though we pronounced the nomenclature differently.

The medical school consists of two years pre-med and four years medicine plus internship.

I completed my studies at Santo Tomas in 1954, and received permission to take my internship in the U. S.

Arrival

I came under the Exchange Program, arriving June 1, 1954. New York was my port of entry.

The first sight of America didn't impress me at all. As a matter of fact, I was very much disappointed. Somehow, I was expecting something really great in this, the leading nation of the world today. I don't really know what I expected but certainly not just the skyscrapers and the stylish automobiles, nor the comforts of living.

But, before long, my idea of the U. S. changed. I made several short trips and had a chance to visit some famous schools and big medical centers. I was first amazed and then thrilled: "This is what makes this country so great! America, land of opportunity," I said to myself. I was seized by a great desire to go back to school. "Here, in this country, I can learn all the things I want to."

Grateful

I was impressed by the tremendous facilities offered for learning, and this opportunity for all to learn who wish it. I saw American boys who had finished high school but who had further ambitions of becoming doctors; they worked as orderlies in the big medical centers. By this they were not only saving money to go to medical school but acquiring at the same time valuable knowledge in furthering their medical careers. Over in China, school is open only for well-to-do people. There is no such a thing as "self-supporting" jobs. There are not even enough jobs for those who have to support a big family. So if your parents can't finance you, the door is closed. I wonder how many Americans realize how lucky they are.

Good Samaritan

I am very grateful to have this chance to be in the U. S. for my postgraduate training and I mean to make the best of it. I had an excellent internship at the Good Samaritan Hospital, Cincinnati, Ohio. And now, though I have been here only a few months, I am already convinced that "Good Sam" in Dayton is one of the best OB training centers in this country. While my country is in war, I intend to remain here, taking every opportunity to better myself, to become a good physician.

Some day when the war is over, I can go back, well trained. "Come out here and help these people." My dear father's words still ring in my ears.

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*Youngblood, V. H.: J. Urol. 70:926, 1953.

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Special report and interview

Physician Placement Agencies

What can an agency do to help you locate? When do you apply? What fees might you expect to pay? Here is Part II of an interview with the director of one of the largest medical placement services in the country

Part I of this interview was published in our March issue.

Ship's surgeon

Q How about such a thing as a ship's surgeon for example?

A Well here again I would go directly to the shipping companies. Remember, these companies prefer a doctor who can stay a reasonable length of time. That is, a year or two at least. They seldom like to take a doctor for just one trip. Sometimes though, they are stuck. A regular ship's doctor, for some reason, can't take the ship out for a trip. Then they may call me. But for a regular ship's doctor, I would advise the man to put an application in with the shipping lines. It's such a complicated maze of information to get, that you'd be doing a real service if you could get it down in simple language. Also, maybe you could save me a few headaches. So often, I have residents coming in who will tell me that they are finishing their residency in July and have about six weeks. They'd like a ship's job. It's just impossible. In the first place, a ship's doctor seldom skips a trip, and never in the winter time—that's when the wealthy travelers are going abroad.

Q Do you often get inquiries from specialists who wish to take on assistants?

A Yes. We have a letter here from a man who wants someone to assist him in his practice in California, a pediatric practice.

Q This pediatrician is located in California?

A Yes.

Q Do they ever have special re-

quirements in such a request?

A Oh yes, quite often. In fact, in this instance, the California pediatrician wants a young man who is a graduate of a particular medical school.

Q Well wouldn't he find a graduate of this school through the school's alumni association?

A Through the alumni association, yes. He probably posted a notice but received no reply. He probably is a graduate of this school himself . . . and since he assumed, and rightly, there would be many graduates of his school in the New York area, he wrote to us. He thought there might be graduates of the school who were now pediatricians and who wished to re-locate, back to the state or area in which they had their medical school.

Q Would you advertise to fill this position or would you fill it from your files?

A First we'd go through our files. These consist of 3x5 cards which carry only name, age, licensure, medical school and preferences as to location.

Q You look these over before you advertise?

A Oh yes, if we find the right man in our files, the first thing we do is to notify him by letter.

Q I see. And if you don't - - -

A Then we would run an advertisement in the journals such as your RESIDENT PHYSICIAN, the *Journal of the American Medical Association*, and so forth.

As founder and director of the New York Medical Exchange, Patricia Edgerly is known personally by hundreds of executives in most of America's major industries. Through her good offices, thousands of physicians have found successful locations in private practice, industry or in institutional positions.

Though located in New York City, Pat's placement service, like most others, has no absolute geographic limit. And like other medical agency directors throughout the nation, Pat's contacts and experience enable her to evaluate both the job and the man, bring the two together when it appears both will benefit. According to Pat:

"The young physician, especially, often feels he has an insurmountable problem — just getting started. He doesn't know where to turn and has no idea of the many and varied opportunities available to him."

Q In other words, you keep your files active.

A Yes we do. It would do the resident very little good at all if we were to take down information and then forget about it. We constantly refer to the files to fill practically all positions available.

Q If I were a resident and expected to complete my residency in July, when would you suggest I get in touch with you by mail?

A Well, as near July as possible. By that I mean an application in

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February would rarely be of any value since most of the positions offered in the month of February are to be filled in that month. Probably the month of May would be quite early enough to write us and get an application.

Q Would you say that would apply to most agencies?

A Yes, I would say so. However, I do understand that many residents who are going to finish up this year are already a bit worried and concerned. They do write us. We even get letters now from residents telling us that they are completing their residency in July, not of this year, but in 1957. Naturally it is impossible for us to forecast what will be available in July '57 but at the same time I do understand why they do this—they want to get things into the works and ahead of time. Generally it's a wonderful rule to follow. But as far as getting a position goes, not just in this field but almost any field, very few positions are offered to be filled six months or a year from now.

Q Well would you have anything for July 1st of this year?

A I just happen to have one opening. If a resident were to come in here today and tell me that he would finish his residency in July, and asked: "what's available?" I would answer that "anything I have for the moment is for immediate appointment. But naturally I would accept an application, and, as time goes on, we will refer to it when we get something for July placement."

As a matter of fact, I wish we knew of openings ahead of time so we would be able to tell men who are finishing in July. It certainly would take the pressure off the residents.

Q In other words, when someone is wanted, he is wanted almost immediately?

A Yes, the great majority, within a month.

Q Now, if a resident were to write you today, what information should he include in his letter?

A Actually all he need do is give us his name and address, the date which he believes he will be available and his first choice of location. Sometimes we may suggest another agency if we feel he would have a better chance there. But primarily the information is so that we may mail him an application form.

Q A form?

A Yes, this is practicaly standard. There is a single page; the resident fills out both sides and returns it to us. Then he is on file with us and we have all the information we need.

Q What if the resident simply answers one of your journal advertisements?

A The procedure is almost the same. They usually say that they are interested in an opening that they have seen in such-and-such a journal. Then we send them an application and they, in turn, fill it out and return it to us.

Q Perhaps we could reproduce this application blank, as a typical example. Are they all about the same?

A They are practically all the same, yes.

Q Do many of your openings come from references, through people you have already placed?

A Oh yes, a great many. Actually that's how our service develops and becomes established. As an example to show you how a referral can become a chain reaction, the other day I received a note from a physician whom we had placed a few years ago with a division of General Motors. As a matter of fact, we placed his boss and he obtained an assistant through us and a chain reaction be-

Name ..... Telephone ..... Date ....., 19...

Present address .....

Permanent or home address .....

Age ..... Date of latest birthday ..... Sex ..... Height ..... Weight .....

What foreign languages do you speak? ..... Are you married?

Have you any children? ..... What are their ages? ..... From what schools were you graduated?

What degrees did you receive? In what years?

.....

.....

Where did you serve your internship? (Give name and location of hospital, length of service. Give definite dates.)

.....

.....

What residencies, if any, have you served? (Give name and location of hospital, length and kind of service. Give definite dates)

.....

.....

In what branches of medicine have you specialized?

What postgraduate work have you had? Give names and addresses of the schools or clinics and the length of time your postgraduate study covered, stating definite dates

.....

.....

.....

Of what medical fraternities and societies are you a member?

.....

.....

In what states are you licensed by examination?

What licenses do you now have which have been secured by reciprocity?

Are you willing to take another state board examination? ..... What preference have you as to locality?

Will you consider other localities? ..... Foreign appointments? ..... Would you consider an appointment requiring a limited amount of x-ray work? ..... Of laboratory work? ..... Requiring an investment? ..... What is the maximum amount you would probably invest? ..... What is the least salary you would accept? ..... When do you wish a position?

.....

.....

Will you please attach a typewritten list of your publications to this application, and on a separate sheet, will you please tell us about your research or any medical awards you have received?

Often our clients ask why our candidates are available; therefore, if possible, will you please give us your reason for relocating?

.....

If you do not have a specialty or if you do have a specialty and will consider other branches of medicine, kindly underscore the branches of medicine in which you are especially interested. The blank lines may be used for special work which we may have omitted.

General Practice
Internal Medicine
Allergy
Cardiology
Diseases of the Metabolism
Endocrinology
Gastro-enterology
Pediatrics
Dermatology
Syphilology
Neurology
Psychiatry
Tuberculosis

General Surgery
Orthopedics
Obstetrics
Gynecology
Urology
Urologic Surgery
Genito-urinary Diseases
Proctology
Neurological Surgery
Thoracic Surgery
Traumatic Surgery
Cancer
Radiologic treatment of
Surgical treatment of

Roentgenology
Radiology
Ophthalmology
Otology, Rhinology and Laryngology
Bronchoscopy
Anaesthesia
Public Health Medicine
Tropical Medicine
Bacteriology
Pathology
Pharmacology
Physical Therapy

TEACHING of:
Anatomy
Bacteriology
Chemistry
Pathology
Pharmacology
Physiology

Please underscore the kind of position in which you are particularly interested: Group Clinic; Assistantship; Industrial; Insurance; Mining; Teaching; School; Student Health; Medical Editorial; Research; Hospital Administration; Location for Private Practice; Hotel; Locum Tenens; Part Time, Pharmaceutical.

gan because the boss wanted to move up. So, we placed him with Standard Oil. Naturally, in that way, his assistant took the higher position and he wanted an assistant. So we placed an assistant with him.

Q In other words all reputable placement agencies become established with individuals and companies?

A Yes. If we do a good job for one physician, then as soon as he needs an assistant or knows of an opening, we hear from him.

Agency fee

Q Now here's a question of interest to anyone considering applying through an agency: what is the fee?

←↓ Typical Agency Application Form

EXPERIENCE—Please give a chronological record of your experience. Kindly be as definite as possible. If you have been in general practice, state where and the length of time you were there.

Please give the names, addresses, titles and official positions of four persons who know of your fitness for the work desired and whose opinions will bear weight. Professional references are preferred. It is advisable that fairly recent graduates give the names of one or two former medical teachers and, also the names of men under whom they served their internship.

1.
2.
3.
4.

AGENCY
CONTRACT AND AGREEMENT

No registration fee is charged. We pay all the initial expenses for stationery, postage, advertising, investigation of references, etc., without collecting a registration fee.

Upon accepting a position through information furnished me by THE NEW YORK MEDICAL EXCHANGE, either directly or indirectly, I agree to pay THE NEW YORK MEDICAL EXCHANGE a fee for their services. For instance, if I am referred to an individual or an institution and after my interview it is decided that another position is more suitable for me, I agree that it is through information furnished me by THE NEW YORK MEDICAL EXCHANGE that I secured the position.

No candidate is in any way restricted in efforts to secure an appointment through other means of any kind. In case the candidate learns of a position through another source prior to receiving notification from THE NEW YORK MEDICAL EXCHANGE, the candidate must immediately notify the EXCHANGE to that effect. Otherwise it is assumed that the candidate is proceeding on information secured through THE NEW YORK MEDICAL EXCHANGE. The EXCHANGE does not guarantee to secure an appointment, but it does assure all who register that their interests will be faithfully represented and that every reasonable effort will be made to secure positions for them. Information of vacancies must be considered confidential and must be used only by the one to whom it is sent. If any candidate reveals this information and by it another secures the appointment, the candidate hereby guarantees that he will be responsible personally for the commission. I agree to hold all information received from THE NEW YORK MEDICAL EXCHANGE or from any of its agents strictly confidential and for my own use and benefit only.

I agree to pay on the following scale:

FIRST: Where the total computed yearly salary or income is less than $3000, a sum equal to one full week's salary, payable in three equal installments, one third at the end of each of the first three weeks of employment.

SECOND: Where the total computed yearly salary or income is more than $3000, the fee is computed on a percentage basis of a yearly salary. For example, on a salary of $3000, the fee is 3% or $90.00; on a salary of $4500, the fee is 3.5% or $122.50; on $4000, 4% or $160.00; on $6000, 4.5% or $240.10. On a salary of $6000 and over, the fee is 5% of the first year's salary only, no matter how high the salary goes. The fee on a percentage basis is due within one month after starting my duties.

THIRD: A position is considered temporary if the duration is for ten weeks or less. The fee due on a temporary position is 10% of the entire amount received. If a position lasts longer than ten weeks, the fee is estimated on a 10% basis of the entire amount received, not to exceed the regular percentage fee.

FOURTH: Location to practice. If a satisfactory location is secured by efforts of the NEW YORK MEDICAL EXCHANGE, the fee charged will be 5% of the estimated minimum yearly income; this to be discussed and arranged.

I agree to the above conditions.

Date _____ Signature _____

A Our fee is set according to New York State law. We are licensed by the City of New York.

First of all there is no registration fee. Some agencies charge $2.00 to be listed by the agency. This registration fee, of course, has a sound reason behind it. There are administrative costs even to setting up a file on an individual. But as I say, in New York, we do not charge this fee.

Q And for your service in bringing together the employer and the employe, the physician and the job?

A On the reverse side of the application form is our contract and agreement with the physician. Basically this defines what our position is in relation to the applicant. It also stipulates the fee for service which we usually charge. Roughly, this agreement states that the fee is equal to 5% of the first year's salary whenever that salary is $5,000 or over. Under $5,000 our fee is reduced one-tenth of one percent for each $100 of annual salary below $5,000.

Q How is this fee payable? By that I mean, is it due immediately?

A No. This is also stated in our contract and agreement form. Many agencies will negotiate terms according to the individual circumstances of the physician.

Q What about your fee for locating a practice for the physician?

A Well, here the fee is 5% of the estimated minimum yearly income for the first year. We usually talk this over between the parties involved and arrive at a mutually acceptable figure.

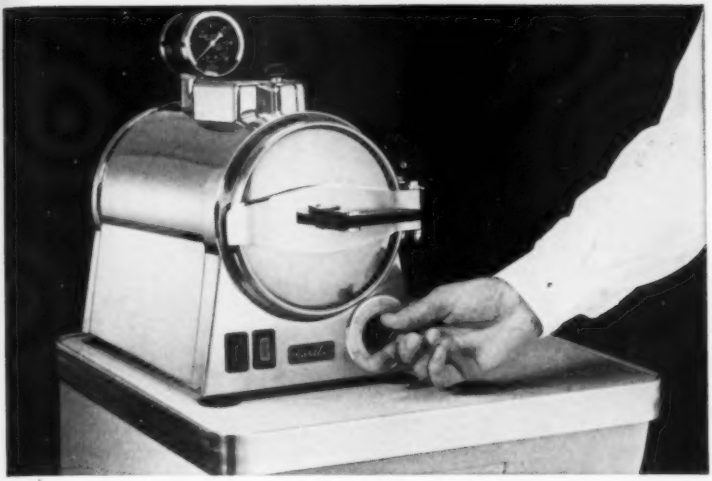
Q What if a doctor applies and you don't feel he has the qualifications for most of the positions offered at your agency. Do you notify him that his application is a dead issue as far as you're concerned?

A Yes, always. For example, if it were a question of references I would write the physician and tell him frankly that I find his references not up to snuff. I think it's only fair that we do this. I think you can say that the established placement agencies generally will give you a frank answer right away if they don't think that they can help you — regardless of the reason. If you were to come in and ask me for a position as an assistant to a specialist at a hospital in San Antonio, Texas, I might immediately advise you to contact so-and-so in that area since they would be much closer to the market than I would.

Q Do you ever have civic groups notify you of an opportunity for a practice in a small town, for example?

A Yes. Very often there are inducements made by the civic groups to secure a physician. Often they will give him a paying school health job to carry him along. Often they offer to find a house for him — and sometimes they even will pay his rent for him.

Q What advice would you have for physicians who are considering setting up a new practice?



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FLEXIN provides superior and long-lasting—up to 6 hours—spasmolysis of voluntary muscle in low back syndromes, fibrositis, strains, sprains, and in noninflammatory rheumatic and arthritic disorders. In one preliminary report of 100 patients, FLEXIN demonstrated "...an 85% over-all effectiveness."[1]

Striking results are reported in cerebral palsy. "The administration of zoxazolamine (Flexin) in 28 children, each of whom had spasticity, produced a decrease of muscular tone on passive flexion in every instance."[2]

Other studies indicate that FLEXIN is of value in a highly significant number of patients with multiple sclerosis,[3,4] as well as in other spinal spasticity states, cerebral vascular lesions and parkinsonism.

(1) Smith, R. T.; Kron, K. N.; Peak, W. P., and Hermann, I. F.: J.A.M.A. 160:745 (Mar. 3) 1956. (2) Amols, W.: J.A.M.A. 160:742 (Mar. 3) 1956. (3) Abrahamsen, E. H., and Baird, H. W., III: J.A.M.A. 160:749 (Mar. 3) 1956. (4) Rodrigues-Gomez, M., Valdes-Rodriguez, A., and Drew, A. L.: J.A.M.A. 160:752 (Mar. 3) 1956.

A Well, this may not sound like expert advice but I would advise them to consider their wives first of all. Perhaps I can explain what I mean. I recently had an opening in another state. A man there had an extremely large surgical practice. He was not a certified surgeon. He wanted a young man, either qualified or certified by the board. So, I notified a resident surgeon who had an application in with us and he went to see the old doctor. They hit it off immediately. I assumed everything was all set. Then I received a letter from the old doctor. He said he was expecting the young doctor to come down but that the doctor had never arrived. So I called the resident, asked him if he was going to take this opportunity. His answer: my wife was at the bridge club the other day and was telling the girls I had the opportunity down in (location of the practice) and one of the women said, "oh, you wouldn't want to live there!"

When the wife came home with the story and the prediction that she wouldn't want to live in that area, the resident decided he'd better not take the opening. The sequel is, six months later the old physician passed away. The entire surgical practice would have belonged to the young man.

So you see why I say that the young physician should consider his wife before he makes a final decision on where he would like to locate or what he would like to do.

Q Are you ever involved in selling an established practice for a physician or his widow?

A Yes, occasionally. Now this might interest residents. Let's suppose a doctor dies and his widow wants to sell the practice, or as often happens, a general practitioner decides to specialize and wants to dispose of his general practice. Often there's a house involved. Perhaps they want $25,000-$35,000 for the house. Then they would like to sell the good-will of the practice. Then they want all the equipment sold. It all comes down to this. The good-will of the practice is an intangible thing—who can guarantee that the retiring physician's patients are going to the new doctor? The doctor says his records are worth something. Yes and no. They may be worth something to him, very little to anybody else. Now the equipment of course is second hand. Any doctor can go out and buy second hand equipment. So what is the doctor actually selling? He is selling a house. And to ask a young man starting a practice for $30,000 to invest in a house is just like asking a bank to loan you money, interest free. It's practically impossible. Our purpose is to try to help the physician who is selling to get a fair price but also to help a man who would like to get started by working out terms which he can handle.

Q Do many residents come to you with the intention of buying a practice?

A Rarely. Generally, when the resident comes to me he is looking for a job. He hasn't any money to speak of and he wants a salary job whether part-time, semi-permanent, or permanent.

Q You mentioned the needed specialties?

A Yes — but I didn't mention ENT and Ophthalmologists. You may remember that at one time the ENT practice practically fell apart. The new antibiotics made a mastoid operation a rarity. Yet we are finding that we almost always have opportunities in both ENT and Ophthalmology. I know the doctors themselves don't realize this yet, that is, that there is a need for these two types of specialists. We had a physician from Belgium in here Monday and he said: "Ear, nose and throat, I thought that is the one speciality that has the least to offer." I told him that many ENT men in New York have patients lined up and waiting from two to four hours every day.

Q What percentage of jobs have fees paid for by the party offering the position?

A It's a very low percentage. It's very seldom that we have the offering party pay the agency fee.

Q What specialists are the easiest to find openings for in addition to those you have already mentioned?

A Well, I would say, in addition to those mentioned, that anyone who has extra work in metabolism or allergy should have an easy time locating.

Q Which would you say is the most difficult?

A I think surgeons and perhaps next, dermatologists. There are very few opportunities here — at least through medical placement agencies.

Q Are there any special difficulties for the foreign graduate?

A Yes. A great many positions require graduates of American medical schools. Even American citizens who take their medical degree abroad will have some difficulty in finding an opening. Yet, as in any field, good men will always find positions. So I advise any resident, regardless of whether or not he is American born, to keep plugging away. Eventually, he will find exactly what he wanted.

Q How are medical placement agencies accredited and by whom?

A They're not accredited. They are independent operations.

Q Do you have many over-seas openings?

A Not at the present time. Right after the war we had many with the oil companies but right now overseas jobs are scarce. Actually, last Friday evening I received a long-distance call from a surgeon in Australia who wanted to spend a few years in practice in the United States. America has become a magnet for many qualified persons and at the same time many of the overseas jobs have been filled by satisfactory people who enjoy their work.


who coughed?
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Q What is the average waiting period between application and final location?

A Actually, I've never stopped to figure it out. I don't think you can say there is an average. I do know this: any doctor who wants a job can get one. But if a physician is finicky and narrows his wants down to a pinpoint, these pinpoints are very hard to hit and take quite awhile. Do you understand?

Q Yes — you mean that the first and second choice of location and possible alternatives of what the physician might like to do would narrow the gap between the date of application and the date of final position.

A In most cases, yes.

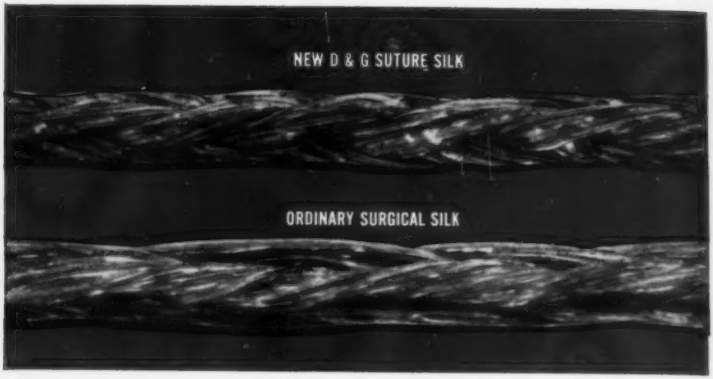
Q For permanent positions, what is the best season for applying?

A I can't tell you what is the best season because it varies considerably. But I would say summer is the worst season, the other three being about equal.

Q What advice would you give to a resident who expects to finish up in July and who would like a position in industry for perhaps a two-year period?

A Well, I would suggest that any resident interested in obtaining any sort of a position or location whether group practice, or assistant, industrial, insurance, mining, further residency training, teaching, school or student health programs, medical-editorial, research, locum tenens, pharmaceutical, or part-time, to get in touch with an established medical placement service in the general area in which he would like to locate. He will then receive an application, probably by return mail. In some states he may pay a registration fee of $2. In others it will cost him nothing to register. In any event, he has at least put himself in a position to hear of openings available. He is free to accept or reject anything referred to him, of course. And I would suggest he get his application in about the middle of May or perhaps the first week of June.

Thank you very much, Miss Edgerly, for your advice and information.



▲ **There's more silk per suture.** Photomicrography shows greater strength and uniformity of new D & G suture silk as compared to ordinary silk. See how the x's indicate the high braid count.

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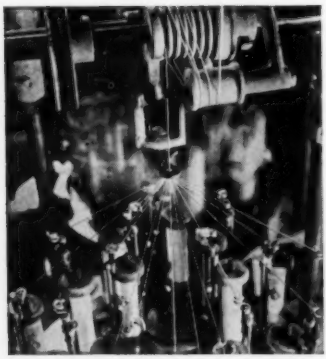

▲ **For greatest strength of silk** in a given diameter, D & G especially redesigned this machine. To braid so many filaments so tightly into a single 10-foot strand of 4-0 silk takes one hour. Rigid control of humidity and temperature during braiding keeps silk uniformly strong and pliable.

This is the new D & G suture silk, the first to be produced in a suture laboratory rather than a textile mill. New processing techniques, beginning with triple-A quality raw silk, provide ANACAP® silk with a higher braid count. A higher braid count gives stronger silk – a firmer, more uniform strand.

There's more silk per suture. Greater tensile strength permits use of smaller-diameter sizes, with less resulting tissue trauma and foreign body reaction. *It's easier to handle.* Braided to minimize "splintering" and "whiskering," ANACAP silk passes readily through tissues. Firmer, it sets in swift sure knots; it won't "bush" – threads with ease. *Absolutely non-capillary,* it has no wick-like action, resists body fluid and won't spread early localized infection. *Economical,* ANACAP silk withstands sterilization at least 6 times.

▲ **Not only uniform tensile strength,** but also uniform texture and diameter of strands result when D & G stretches wet silk from 5% to 20%, depending on size. This precise stretching aligns the molecules for utmost strength.

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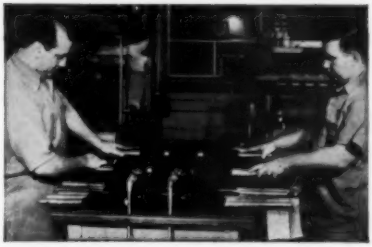

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Ophthalmology Board Requirements

Knowing exactly what's required often prevents confusion and costly misunderstandings. Here are essential facts for quick review. When your particular specialty appears, mark the cover and binding of the issue for ready reference.

The information contained in this article was obtained through direct correspondence with the specialty board. Current news such as changes in requirements, special announcements, and notices of date and place of examination will be published in *Resident Physician* as received from the various boards.

The American Board of Ophthalmology, the first specialty board, was incorporated in 1917. It was organized by joint action of the American Ophthalmological Society, the Section on Ophthalmology of the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology. Since 1934, each component society elects one member to the Board each year to serve a four year term.

Purposes

In brief, the Board was set up to:

1. Elevate the standards of ophthalmology.
2. Determine the competence of ophthalmologists who desire certification.
3. Conduct examinations for candidates who appear before the Board and to issue certificates to those who pass.
4. Act as advisors to prospective students of ophthalmology.

Basic requirements

1. High ethical and professional standing.
2. Full citizenship in the country where the candidate practices. (Limited to countries of North and South America, their possessions and territories and the Philippine Republic).
3. A degree from a medical school of high standing, satisfactory to the Board and approved by the Council on Medical Education and Hospitals of the American Medical Association. An applicant whose undergraduate training has been received outside of the United States or Can-

ada, must present credentials satisfactory to the Board and is required to have the certificate of the National Board of Medical Examiners if in practice less than ten years.

4. Completion of an internship of not less than one year in a hospital approved by the Council.

Special requirements

1. Completion, by the time of the written qualifying test, of not less than 36 months (a total of 60 months is required of candidates practicing both ophthalmology and otolaryngology) of combined study, training and practice of ophthalmology in approved medical schools, hospitals, clinics, dispensaries, laboratories, preceptorships and private practice.

4. *Applicable to applicants who start residencies in ophthalmology after December 31st, 1956:* Individuals who have completed three years of formal ophthalmological training (residency and basic science courses) may apply for the written qualifying test after completion of 12 months of practice or 12 months of institutional work, a total of 48 months. All other individuals (with less formal training) may apply for the written test after 60 months in ophthalmology or 72 months of combined ophthalmology and otolaryngology. A basic course is recognized as equivalent in time to residency training. All time requirements must be completed by the date of the written test.

Special training

Required special training includes both graduate of the basic sciences and clinical experience.

A. Graduate study requirements may be satisfied by: 1. A curricular course in the basic sciences related to ophthalmology in an approved graduate medical school.

2. Postgraduate study. Courses in individual basic sciences related to ophthalmology (offered at various approved institutions). The home study course of the American Academy of Ophthalmology and Otolaryngology is recommended as a supplement.

3. Residency. Advanced study of these subjects during a residency and by correlation of the principles involved with clinical problems.

4. Research, fundamental and clinical. By the detailed study, under supervision or as an assistant to an experienced research worker, of some problem or topic which brings the basic sciences down to the concrete clinical problem.

NATIONAL PHENOMENON: THE PLANNED BIG FAMILY

THE PROPHETS OF DOOM who talked of the nation's dwindling population were never more wrong. Today improved economic and social conditions are resulting in bigger families – *planned* big. Families of three or more children have increased 47 per cent during the past seven years.[1]

Pregnancies wanted – Women seeking advice today on conception control want to make sure that the method recommended will not impair future fertility. For a dependable method that permits conception *when* it is wanted, the diaphragm-jelly method has no equal. Of regular users who discontinued the method in the hope of conceiving, "25 to 30 per cent achieved pregnancy within one month."[2]

Comfort, peace of mind – RAMSES® Diaphragm and Jelly combine comfort for the patient with confidence in the method. The flexible, cushioned rim of the RAMSES Diaphragm assures the utmost freedom and comfort. RAMSES Jelly, "the 10-hour jelly" because it occludes that long, quickly immobilizes sperm and is non-irritating.

Patients who want their families *when* they want them will rely on these RAMSES products as physicians have done for more than thirty years: RAMSES "Tuk-A-Way"® Kit (#701)—diaphragm, introducer and jelly, RAMSES diaphragms 50-95 millimeters, RAMSES jelly in 3 and 5 oz. tubes.

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1. U. S. Census. 2. Tietze, C., in Dickinson, R. L.: Techniques of Conception Control, ed. 3, Baltimore, Williams & Wilkins Co., 1950, pp. 55-57.

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B. Clinical experience in approved hospitals, clinics, dispensaries and private practice. This can be met by:

1. Residency in an approved hospital. The most desirable program will have regular lectures covering the entire field of clinical ophthalmology and of the subjects as applied in clinical practice. (In hospitals where regular instruction by lectures and quizzes and seminars is not available, residents may be guided by the syllabus issued by the Board.)

2. Fellowship in ophthalmology.

3. Preceptorship with a well-trained and critical ophthalmologist.

4. After completing a residency it is of advantage to secure a position in a clinic as fellow or assistant. This may require only part time work, but due credit will be given.

Military service

Credit for military service is given on an individual basis, each case being considered on its own merits. The amount of credit allowed is determined by the Board from information in the application.

Application and fees

1. Completed application forms, letters of endorsement, together with other required credentials must be sent to the Secretary's office before the published closing date.

2. A fee of $100 is required with application.

3. A list of papers or books published is to be included.

4. A list of ophthalmic operations is required.

For the original clinical examination, a fee of $50 is payable on successful completion of the written test. Repeating written test, $65. Repeating clinical examination, $65. Single conditions, $25. Two or more conditions, $35.

Qualifying examination

Before being accepted for examination, candidates are given a written qualifying test. The questions may cover any part of ophthalmology and concern primarily the following listed subjects. The written test will be given in several principal cities at the same time. Choice of cities is determined largely by the geographical distribution of candidates. Candidates found acceptable will be notified to appear for a subsequent *practical* and *clinical* examination in ophthalmology.

Clinical examinations

All written examinations are of the multiple-choice type. Practical and

clinical examinations are held annually at or near the time and place of the meeting of the American Medical Association; also at other times and places at the discretion of the Board and depending upon the number of applications from any region. Examinations are as follows:

1. *External Diseases* of the eye and adnexa. Various methods of examination, diagnoses and treatment.

2. *Ophthalmoscopy*. Patients will be examined by the candidate and the findings described or drawn. A candidate is required to bring his own ophthalmoscope.

3. *Pathology*. The candidate will demonstrate familiarity with general clinical pathology as well as the etiology, pathology and bacteriology of diseases of the eye. He will be asked to examine microscopic slides and to recognize normal and pathologic histology of the eye.

4. *Refraction*. A candidate will examine patients and show mastery of various methods, and of the principles of refraction and of retinoscopy. He should bring his own retinoscope.

5. *Motility*. The candidate will demonstrate upon patients his familiarity with routine methods of examination and diagnosis.

6. *Ophthalmic Surgery*. Examination of surgical patients and discussion on principles of ophthalmic surgery.

7. *Perimetry*. The candidate will be given the opportunity to examine patients by use of the arc perimeter, the tangent screen and the stereocampimeter. He may also be required to interpret charted fields.

If a candidate fails three or more of the seven practical subjects, he must take the entire examination again. If he fails one or two subjects, he may take these subjects again, at a regular examination of the Board.

Review of surgical cases

The Board requires of all candidates a list of ophthalmic operations performed within two years prior of examination. The list is to be presented with the application and prepared according to detailed instructions obtainable from the Board Secretary.

Re-examination

Candidates may be re-examined as often as they desire on satisfactory evidence of adequate additional preparation and payment of re-examination fee. When a candidate is conditioned in one or more subjects the Committee on Examinations shall decide on the merits of the case and the length of time that

must elapse before re-examination in these subjects. A minimum of two years additional preparation is required of candidates who fail in all subjects. The Board may, at its discretion, deny the candidate the privilege of re-examination.

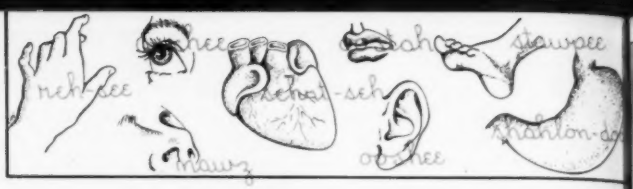
Certification

The decision of the Board is final as to the candidate's passing, failure, or partial failure. The final action of the Board is based upon the candidate's ethical and professional record, training and attainments, as well as on the results of his formal examinations.

Information

Additional information may be obtained by writing to: Merrill J. King, M.D., American Board of Ophthalmology, Box 236, Cape Cottage, Maine.

"The only significant evidence, Mrs. Weber, is a rather large mouth!"



The Doctor Speaks Polish

The problem of language barriers is common, especially in large hospitals or in medical centers located in areas populated by one or more foreign born groups.

Some in these groups do not speak English at all, many others only haltingly. And for the majority, the English forms of many medical and anatomical terms have no meaning.

Because the average resident cannot devote the time required to master many foreign languages, RESIDENT PHYSICIAN presents this sixth in a series of brief guides to foreign phrases in the more common languages spoken in the United States.

The completed series of language guides, including French, Spanish, Italian, German, Polish, and Yiddish, will be reprinted and bound as a booklet available at cost.

Keep your "language finder" open in front of the patient and don't worry too much about the pronunciation of words. Your patient will be eager to help.

In the Polish translation that follows, you will find no written Polish. Instead, the pronunciation of the Polish equivalent of each English word listed is indicated by a manufactured word in English. By saying the strange-looking word formations aloud (just as you would if they were real English words), you will approximate the sound of the Polish or perhaps it would be more accurate to say you will be in the general vicinity of the correct Polish pronunciation.

Remember, there are many Polish sounds which have no equivalent in English. On many words you will be "close, but not quite." However, the purpose of this translation is not to make you a linguist, but simply to give you a concise and handy pronunciation guide by which you may more easily communicate

with the foreign-born patient. If we were to list all the rules of pronunciation along with the written Polish, this guide would undoubtedly help you to a more accurate pronunciation—but at the same time it would be so cumbersome and technical as to defeat its original purpose of being quick and easy to use during an examination or history of your patient. Incidentally, we do not use the standard phonetic alphabet since few individuals can *sight read* phonetics.

For examination of Polish-speaking patients:

Basic rule of pronunciation

g is always pronounced hard as in *go, give,* never as g in ginger

Anatomical terms

head	glaw-vah	neck	sheeyah
eyes	awchee	chest	klahtkah pee-air-showvah
ears	ooshee	heart	sehrt-seh
nose	nawz	lungs	ploo-tsah
mouth	oostah	shoulders	bar-kee
teeth	zahmbee	back	pletsee
tongue	yehnzek	arm	rahm-yeh
throat	gardlaw	bladder	pan-kash
finger	pahlats	stomach	shahlon-doc
legs	no-gee	rectum	kishah awd-kawddovah
feet	stawpee	buttocks	tilleck
hands	reh-see	womb	mah-chitzah

Directions to patients

do as I do	rawbich toe so ya rawbyeh
relax	awdprehshich sheh
relax more	vyehcheh sheh awdprehshich
open your mouth	awdvawshich oostah
open your eyes	awdvawshich awchee
breathe deeply	awdickach glehboko
breathe through your mouth	awdickach pshaz oostah
hold your breath	zatsheemach awdech
push	puhnawch nahpnawch sheh
cough	kahshlach
please don't move	prawsheh sheh rooshach

How CARNATION INSTANT provides new dietary advantages not possible with other forms of nonfat milk

Because Carnation Instant is a new *crystal form* of nonfat dry milk, the physician may specify a greater ratio of milk solids to water than supplied by bottled nonfat milk. The new crystal form may also be added to *whole* milk to increase its nutritive content.

WHEN LIQUIDS ARE RESTRICTED, the physician may specify an additional heaping tablespoon of Carnation crystals per glass (or ⅓ cup additional crystals per quart.) This "self-enrichment" provides a 25% increase in protein, calcium and B-vitamins with no increase in liquid bulk.

25% "self-enriched" Carnation Instant also provides a more familiar heavier texture and richer flavor, well-liked by patients who are accustomed to drinking whole milk.

WHEN PROTEIN NEEDS ARE HIGH, the physician may recommend the addition of 1⅓ cups Carnation crystals to each quart of *whole* milk. This *doubles* the protein, calcium and B-vitamin content.

The use of Carnation Instant in whole milk is of value for children who are in a temporary phase of "milk resistance"... and is also useful in increasing the protein in convalescent diet without increasing bulk.

Other advantages of the Carnation exclusive Crystal Form

Fresh milk flavor, delicious for drinking.
Mixes instantly in ice-cold water.
Does not cake or harden in the package.
No special recipes needed.
Economical, available everywhere.

Courtesy phrases

Good morning, Sir	jen dawbry pahnue
Good evening, Madam	dawbry v-yetshur
Good night	dawbrahnawts
Please	prawsheh
Thank you	jenk-you-eh
Please sit down	prawsheh you-sheeshch
How are you?	yahk shee chew-yehchee
Very well thanks	bardzaw dawbr-jeh jenk-you-eh
May I help you	chee mow-geh pawmuts
Do you understand	rawzumyesh
Pardon me	pshahprahshahm
Very good	bardzaw dawbr-jeh
Today	chishay
Tomorrow	yewtro
Yesterday	vuhchoray

General questions

do you feel sick	chee chew-yehcheh sheh kor-rim
do you have pain	chee mahcheh booleh
— much pain	— awstreh booleh
— mild pain	— slahbeh booleh
where	guhjeh
here	tootay
when	k'yaidee
how many years	illeh latt
how many days	illeh'dnee
how many hours	illeh gawjin
how many times	illeh rahzy
where were you born	guhjeh uhrawdzony
how old are you	illeh mahcheh latt

Diseases

measles	awdra
scarlet fever	shcarlahteena
chicken pox	vyechna awspah
small pox	awspah
pneumonia	zahpahlenyeh plootz
typhoid fever	tyfuss
enteritis	zahpahlenyeh kishehk
U.R.I.	zahpahlenyeh goornych drog awdehchowich

Systemic inquiry

Head	
trauma	oodehshenee
unconscious	nyepsheetomnee
did you faint	chee m'dleh-lish-cheh
are you dizzy	chee mahcheh zavrawty glaw-vee
headache	bull glaw-vee
Eyes	
sight	vzrawk
clear vision	virahshnee awbrass
near	bleesko
far	dahlehko
Ears	
he is deaf	on yest glookee
noise in the ears	shumm vuh ooshahk
Nose	
coryza	kahtar
did you have a nose bleed	chee mahcheh krah-vah vyen yeh nawsah
Throat	
do you have frequent sore throat	chee macheh chensteh booleh gardlah

Cardio-respiratory

do you tire easily	chee lehko oolehgahcheh smehchenyoo
are you short of breath	chee brahkooyeh vahm awdekoo
does your heart beat fast	chee mahcheh pchee-speeyay-shawnay bicheh sersah
do your feet swell	chee pooknaw no-gee
do you have pain in the chest	chee mahcheh booleh vuh plootzahk
sharp pain	awstree bull
dull pain	tehpee bull
when you breathe	pchee awdichahnyoo
do you cough	chee kashlehcheh
do you spit	chee sploovahcheh
sputum	puhlvachinah
bloody sputum	puhlvachinah zuh kriv-yone
have you lost weight	chee strachlishcheh nah vah-zeh
does someone in your family have a cough	chee kuhtahsh zuh rojinee kashlahl

Gastro-intestinal

do you have a good appetite	chee mahcheh dawbry apehtit
do you have a poor appetite	chee nyeh macheh apehtit
are you nauseated	chee chee-ehcheh vimee-awtovach
were you nauseated	chee k'cheh-lishcheh vimee-awtovach

do you vomit	chee vimee-awtehyecheh
do you have diarrhea	chee mahcheh roz-vall-nych-nych
are you constipated	chee mahcheh zahtvard-jenyeh
did you have a B.M. today	chee mee-elishcheh jishay stawlets
feces	
black	charnee
white	beeyellee
yellow	shuhltee
brown	brawnsovee
bloody	krah-vah-vee
do you have cramps	chee mahcheh koorcheh
after meals	po yedzenyew
before meals	pshed yehjenyem
did you take a laxative	chee brawlishcheh nah psheh-chish-chehnyee
did you take castor-oil	chee brawlishcheh olay reetseenovee

Genito-urinary

urine	mawch
do you get up at night to urinate	chee viztayecheh vuh nawchy awdahvahch mawch
does it burn	chee p'yecheh
chills	dreshcheh
fever	guh-rahnch-kah

Obstetrics and gynecology

at what age did you begin to menstruate	keeyaidee mee-elishcheh p-yairvshah menstrooats-yeh
How many days do you flow	yahk d'loogaw menstrooyetsee
1 to 10	roz, d'vah, cheh, shteveh, pee-ench, sheshch, shedem, awshum, jev-ench jeshunsh
do you have a discharge	chee mahcheh ooplahvee
when was your last menstrual period	keeyaidee awstaht-neo mee-elishcheh menstrooyets-yeh
are you pregnant	yes-tesh-tschee vuh kee-ah-shee
do you have pain with your period	chee mahcheh booleh podtshohs menstrooats-yeh
how many times have you been pregnant	illeh rahzee beelishcheh vuh kee-ah-shee
how many children have you had	illeh mee-lishcheh jet-shee
how much did the largest weigh at birth	yahkah nay-vyenkshah vahgah beelah p'chee oorawzenyoo
what was the duration of labor	yahk d'loogaw truhvahlee booleh porawdo-veh

Pediatrics

was there any trouble with the child's delivery	chee pawruhd bill skawm-pleekahvanee
how are the child's stools	yahkee yest jets-kah stawlets
— constipated	— zawt-vahrd-shawnee
— diarrhea	— roz-vall-yony
— how many a day	— illeh rahzee jenyeh
does the child eat well	chee jeh-kah yeh dawbr-jeh
any vomiting	chee vimee-awtoyetsheh
does the child turn blue	chee jeh-kah sheen-yieyeh
does the child seem tired	chee jeh-kah veeglondah smenchawneh
does it hurt	chee bowlyee
it won't hurt	taw nyeh ben-jeh bowlech
it will be over in a minute	taw skonchee shieh tsa chvilleh
do you want a piece of candy	cheesh tsookee-airkuh
did you take the temperature	chee mee-eshy-lesh-shee gorahnchkuh
what was the temperature	yahkah gorahnchkah
what a big handsome boy	yahkee lahd-nee klawpuk
what a beautiful little girl	yahkah schitshnah jeff-chinkah
baby	nee-maw-vleh
good	dawbsheh

This is the final article in our series on language guides. Designed to aid the resident with his examination and history-taking of the foreign-born patient, the language articles (French, Italian, German, Polish, Spanish and Yiddish) are being combined and reprinted in booklet form.) A limited number of copies will be available at cost ($1.00 per copy in coin or stamps) from the publisher. Address: Resident Physician, Reprint Department, 680 Northern Blvd., Great Neck, L. I., New York. House officer associations please note: Reduced rates (available on request) for orders of 10 copies and over.

THE CLEAREST ring of sincerity often sounds in what some may haughtily dismiss as "unpolished prose." No Churchill or Shakespeare is Dr. Deza. Yet, writing in a language not native to him, he elected not to snow the reader beneath a blanket of brightly-worded flummery loaded with clinical obscurities. Instead he wrote of what he feels. The lesson he is learning from his patients, as he describes it in his article, might be called "obvious" except for one thing: it is a lesson taught over and over again by many patients to many doctors in every specialty. But only the receptive and responsive, the most humble, ever learn it by heart. Perhaps Dr. Deza's prose may help get it across where a more "polished" effort would fail. Ed.

I Learn From My Mental Patients

Ernesto C. Deza, M.D.

As a resident in psychiatry, I am learning much from my mental patients. I have not read in books some of the things I have learned from them. Other things I learn come as illustrations of statements by dry and highly technical authors and students of psychiatry.

I am learning to be more humanitarian in my attitudes. My patients teach me daily to be so. For instance, some of them have told me, "Just because we are in a mental hospital, we are still human beings and are entitled to self-respect." Many of them complain that society rejects or shuns them when they could not help getting sick in mind or emotions.

I am more and more amazed daily by the "antennae" of my mental patients. Even before I am conscious myself of my own feelings or even before I define them, my patients always sense any hostility or fear I have. Many a time I have been told, "You don't have to fear us. We won't hurt you."

You can't fool mental patients. They can penetrate thru your lip service or false smiles and verbosity. If you are rejecting, they can sense your insecurity very quickly. They are really acutely sharp in the look-

out for repeated hurts. Society forced them to be that way. Show them, however, persistent and unalloyed kindness and they also respond. They are not that "way off" or inaccessible.

I am daily taught by my mental patients that if you fear their hostility, you just don't know how much they also fear it. Sometimes more than you. Some of my patients frequently repeat, "I have not done wrong. I won't hurt anybody. I won't." So far, not one of my mental patients has ever hurt me yet. And I can't seem to believe it, for I worked for more than a year in a most disturbed ward.

That the resources of man for recovery are tremendous has been taught me vividly by mental patients. I have given up some of them for "lost souls" before, only to find out later how wrong I could be in my pessimism. Unexpected recoveries in mental patients you least expected to "bounce back" to their "normal selves—"this is a leavening experience and conducive to more positive and optimistic attitudes of life in general.

You have to make persistent overtures to mental patients, more so if they are highly withdrawn or seclusive. Your efforts pay tremendously. The results of trying to gain their trust, rebuild their hurt or destroyed ego, and accept them in spite of their bizarre ideas are highly satisfying, though hard. Especially if they provoke me, I have found out it requires real understanding of dynamics of mental disease and deep kindness not to retaliate, run into anxiety panic, or give up.

Mental patients are really people, capable fundamentally of warmth, affection, and respect. This fact is new and surprising to me. My mental patients surely are interesting, stimulating, and markedly educational. But not if I keep my mind and heart and ears from them. This lesson alone is something.

TAUNTON, MASSACHUSETTS

Calling All Residents

To be certain you won't miss a single copy of RESIDENT PHYSICIAN, please notify us *at least 30 days in advance* of any change in your *hospital* mailing address. Simply drop a card to RESIDENT PHYSICIAN, 676 Northern Blvd., Great Neck, N. Y. *Please state both old hospital and new hospital addresses,* your specialty, and the name of your chief of service.

What's the Doctor's Name?

James Gallagher

He was born October 25, 1924, in Seattle, Washington.

He attended Galileo High School in San Francisco.

Though his father wanted him to be a professional baseball player because of his outstanding ability at this sport, he wanted to become a doctor.

In 1941, he entered Stanford University as a pre-med student. His medical studies (at Stanford, later UCLA and Tulane) were interrupted by service in the United States Navy.

His natural athletic talent led the New York Yankees to acquire him in 1946. The Yankees paid him a bonus estimated at $50,000 to sign a baseball contract—the largest bonus ever paid to an amateur.

In the 1946 World Series he was used as a pinch-hitter; he walked once, hit two doubles and a single in four trips against Brooklyn pitching for a history-making average of 1.000. He batted .500, .333, and .357 in the 1949, 1950, and 1951 Series for a .439 average.

While playing baseball with the Yankees he continued his study of medicine in the off-seasons. In 1951, he received his doctor of medicine degree and interned at San Francisco Hospital.

His twin career gave rise to many humorous situations. As one story has it, he was engrossed in a medical journal in the Yankee dressing room one afternoon when the Yankees' colorful catcher, Yogi Berra, sat down beside him. Berra, who was considered to be a devoted comic book fan, asked, "What's that you're reading?" The doctor replied: "Pathology of the Intestinal Tract." Yogi grunted an acknowledgment of this information and left the dressing room for the field. About a week later, the catcher again was sitting alongside the doctor. "Didja finish the book?" "Yes," replied the doctor absently. "How did it come out?" said Mr. Berra.

Can you name the doctor without turning to page 130?

Mediquiz

Questions are from a civil service examination recently given to candidates for physician appointments in municipal government.

Answers on page 130.

1. Osteitis fibrosa cystica is characteristically associated with: (A) hyperthyroidism; (B) hypoparathyroidism; (C) hyperparathyroidism; (D) hyperpituitarism.

2. The one of the following statements in regard to influenza which is the least accurate is that: (A) influenza may be due to one of several virus types and an attack with one type does not produce effective immunity against other types; (B) the transmission of true influenza can be checked by early administration of suitable antibiotics to the patient; (C) the patient with influenza will not transmit the live infection to others after the first week of infection even though symptoms may persist; (D) the incubation period of influenza is often less than 24 hours and the patient may even infect contacts before manifesting symptoms.

3. A police detective who had been assigned for ten years to the task of developing and photographing fingerprints found increasing difficulty in performing his work because of a tremor of the hands. An investigation revealed that he was suffering from an occupational disease. Among the materials which he handled, the one which was the most likely cause of his symptoms is: (A) metol; (B) printer's ink; (C) hydroquinone; (D) mercury.

4. The one of the following which is the most important anatomical structure in making it possible to reduce a compression fracture of the body of the first lumbar vertebra by hyperextension is the: (A) posterior longitudinal ligament; (B) interspinous ligament; (C) ligamentum flavum; (D) anterior longitudinal ligament.

5. A "string" sign is seen radiologically in: (A) lymphopathea venereum; (B) terminal ileitis; (C) basal atelectasis of the lung; (D) cardiospasm.

6. Urobilinogen in the urine is most likely to be absent in: (A) cirrhosis of the liver; (B) acute yellow atrophy of the liver; (C) adenocarcinoma of ampulla of Vater; (D) gallstone in cystic duct.

7. The serum protein-bound iodine of a patient is found to be 12.0 micrograms per 100 cc. and the urinary excretion of a diagnostic dose of I^{131} is 10 per cent in 24 hours. The presumptive diagnosis is: (A) euthyroidism; (B) myxedema; (C) carcinoma of the thyroid gland; (D) hyperthyroidism.

8. The one of the following nerves which lies in a superficial position near the knee and is liable to injury is the: (A) peroneal nerve; (B) sciatic nerve; (C) femoral nerve; (D) posterior tibial nerve.

9. The arthropod vector of Rocky Mountain spotted fever is the: (A) body louse; (B) mite; (C) anopheles mosquito; (D) tick.

10. A petechial eruption is most likely to be found in: (A) H. influenzae meningitis; (B) typhoid fever; (C) meningococcus meningitis; (D) coccidioidomycosis.

11. In diabetic acidosis treated with glucose, insulin and fluids, weakness and low T-waves in the electrocardiogram suggest: (A) low serum potassium levels; (B) acidosis; (C) hypoglycemia; (D) low serum carbon dioxide combining power.

12. Sensitivity to insulin is seen frequently in: (A) Cushing's syndrome; (B) diabetes insipidus; (C) hyperthyroidism; (D) Addison's disease.

13. A convulsion following olfactory hallucinations suggests: (A) an intranasal tumor extending intracranially; (B) a lesion of both olfactory bulbs; (C) a lesion of one olfactory bulb; (D) a temporal lobe lesion.

14. Five days after a severe head injury, a man develops progressive proptosis of one eye. The most likely cause of this condition is: (A) fracture of supraorbital ridge; (B) retrobulbar hematoma; (C) arteriovenous cavernous sinus fistula; (D) massive hematoma into sphenoid and ethmoid sinuses.

15. Of the following, the one not associated with hypoparathyroidism is: (A) muscle cramps; (B) high serum phosphorus; (C) cataracts; (D) renal calculi.

16. Lysozyme titre determination is a laboratory procedure of value in: (A) rheumatoid arthritis; (B) ulcerative colitis activity; (C) sarcoidosis; (D) periarteritis nodosa.

17. The presence of a "Blumer" shelf is determined by: (A) flat plate x-ray of abdomen; (B) digital

examination of rectum; (C) use of Miller-Abbott tube; (D) abdominal palpation.

18. A rising titre of heterophile antibodies is most characteristic of: (A) infectious mononucleosis; (B) dengue fever; (C) measles; (D) rheumatoid arthritis.

19. In a young male patient with a single painless nodule in the thyroid gland the most advisable management is: (A) observation for evidences of enlargement or until other nodules appear; (B) simple excision; (C) the administration of radioactive iodine; (D) thryoidectomy-subtotal.

21. A 50 year old man with proven to occur most commonly in: (A) atrophic testis following mumps; (B) a testis which descended into scrotum at puberty; (C) abdominal ectopic testis; (D) a testis associated with a scrotal hernia.

21. A 50 year old man with proven pneumococcal pneumonia had a good initial response to penicillin therapy but, four weeks after onset of pneumonia, a segment of the involved lobe remains consolidated and some fever and cough persist. Of the following, the course of action which should be followed is to: (A) give patient a course of aureomycin; (B) test pneumococci from patient to see if they are resistant to penicillin; (C) bronchoscope patient.

Leads and Needs

Rates

Personal classified advertising rates are $3.00 for ads of thirty words or less plus 10c for each additional word. When a box number is used and answers sent care of RESIDENT PHYSICIAN there is an additional charge of 50c. Add four additional words for a box.

Commercial classified rates are $4.50 for ads of twenty words or less plus 15c for each additional word. Commercial rates include all ads of manufacturers, dealers, agencies, etc. Count four additional words for a box.

ALL CLASSIFIED ADS PAYABLE IN ADVANCE. Forms close 15th of month prior to date of issue. RESIDENT PHYSICIAN, 676 Northern Boulevard, Great Neck, New York.

RESIDENTS WANTED

HOUSE PHYSICIANS WANTED; 345 bed general hospital; rotating service; $200 month, room and board furnished; must speak fluent English; apply immediately for July 1st appointment. Kentucky Baptist Hospital, Louisville, Kentucky, H. L. Dobbs, Administrator.

ROTATING RESIDENCIES—general practice available July 1, 1956; salary $400 per month; must be citizen; 100 bed hospital; well-equipped and with full accreditation on Joint Commission. Write: Administrator, Tulare County General Hospital, Tulare, California.

PEDIATRIC RESIDENCY (approved in Medical school hospital). Active clinics; including adolescent, allergy and mental retardation. Affiliation for contagious diseases. Teaching conferences and seminars. Newborn service. Man or woman accepted. Salary $110 per month, plus full maintenance.

FELLOW-ANATOMIC, clinical, experimental pathology; from July 1, 1956 on; not a residency; remuneration depends on qualifications, future on services. Send curriculum with 1st letter to: P.O.B. 228, Dover, Delaware.

COMMUNITY HOSPITAL (small) needs additional doctor; training in internal medicine desirable. Write: Griggs Community Hospital Association or to Dr. Wakefield, Cooperstown, North Dakota.

RADIOLOGY RESIDENCIES AVAILABLE — Veterans Administration Hospital; large 2000 bed General Medical and Surgical Hospital, fully approved for three years' training; citizenship required. Apply: Chief, Radiology Service, Veterans Administration Hospital, Hines, Illinois.

GENERAL PRACTICE—Residents wanted for 238 bed county general hospital 25 miles from San Francisco. Approved for G.P. by A.M.A. Excellent teaching program, $300 plus maintenance. Dr. J. Paul Sweeney, 210 39th Avenue, San Mateo, California.

APPROVED RESIDENCIES—VA Hospital; integrated programs, Baylor University Affiliated Hospitals, Texas Medical Center. Vacancies Internal Medicine, Neurology, Ophthalmology, Otolaryngology, Pathology, Physical Medicine, Psychiatry and Urology; $2840-$3550. Career residencies, Neurology, Psychiatry and Physical Medicine; $5915-$8990. Manager, VA Hospital, Houston, Texas, or Dean, Baylor University College Medicine, Texas Medical Center.

SURGEON WANTED—254 bed general medical and surgical hospital. Surgical Service supervised by full time board certified surgeon. Ideal for man finishing residency. Hospital located at home of University of Arkansas and in the heart of the Ozarks. Limited number of housekeeping quarters available. Contact Manager, VA Hospital, Fayetteville, Arkansas.

APPROVED RESIDENCIES—Internal Medicine available quarterly, Veterans Administration Center, Dayton, Ohio; 3-4 year program. Citizenship required. Affiliated and supervised by Ohio State University Medical School. Salary $2840-$3550 per year. Approved for benefits under Public Law 550. Apply: Dr. S. Simerman, Chief Medical Service, VA Center, Dayton, Ohio.

MEDICAL RESIDENCY—Available immediately at approved 700 bed general hospital; 3-year approval for internal medicine; salary $235 per month. Apply Supt., San Joaquin General Hospital, P. O. Box 1890, Stockton, California.

PSYCHIATRISTS, PSYCHIATRIC RESIDENTS, and general physicians—Indiana's most progressive mental health program; assistant superintendents, clinical directors, chiefs of service, $11,700-$14,700; psychiatrists, $9,300-$12,900; psychiatric residents, $4,380-$5,760; general physicians, $6,900-$9,900; U. S. citizenship and Indiana license required. Write: Division of Mental Health, 1315 West 10th Street, Indianapolis 7, Indiana.

ANESTHESIOLOGY RESIDENCIES—University of Utah and affiliated hospitals, 1st year and 3rd year available now and July 1st. Active teaching program; excellent salary; fully approved. Contact: Carter M. Ballinger, M.D., Division of Anesthesiology, University of Utah, Salt Lake City, Utah.

UROLOGIST: Board or eligible; citizenship required; 382 bed medical and surgical hospital; salary $8,990 to $13,760, depending on qualifications. Quarters may be available. Contact: Manager, VA Hospital, Muskogee, Oklahoma.

CHIEF RESIDENT: medical or surgical residents needed on 7/1/56; Cincinnati, Ohio hospital; for 150 bed hospital. Teaching program one year approved AMA residencies. The Deaconess Hospital, Cincinnati 20, Ohio.

PHYSICIAN—staff associate; private psychiatric hospital in beautiful Finger Lakes region of New York State; full maintenance for couple available; salary commensurate with experience and training. Contact: Brigham Hall Hospital, Canadaigua, New York.

RESIDENCY APPOINTS still available—limited number. Vacancies exist in following categories; 1st year, Obstetrics—Gynecology; 1st and 2nd year, Straight Obstetrics; 1st year, Pediatrics; 1st and 2nd year, General Practice; 1st thru 4th year, Pathology; Urology (combined program with Indianapolis General Hospital). All other appointments filled for 1956-57. Stipend range $278 thru $362 per month. Fully approved, well-organized programs. Outpatient service; U. S. and Canadian graduates only. Apply: Superintendent, Methodist Hospital, Indianapolis 7, Indiana.

OPPORTUNITIES AVAILABLE IN VIRGINIA—For vacancies to be created by retirements beginning March 1, 1956. (1) Two assistant directors of local health departments; applicants without public health training or experience given on-the-job training and paid a beginning salary of $8400; must be under 38. (2) Two directors of local health departments; salary $9600 to $11,472; must be under 50 with recognized public health training experience; applicants must be American citizens and eligible for Virginia licensure; liberal sick leave, vacation, and retirement benefits. Write: Director of Local Health Services, State Department of Health, Richmond 19, Virginia.

CHIEF RESIDENT: medical or surgical residents needed on 7/1/56; Cincinnati, Ohio hospital; for 150 bed hospital. Teaching program one year approved AMA residencies. The Deaconess Hospital, Cincinnati 20, Ohio.

PRINTING and RECORDS

RESIDENTS WANTED

INTERNAL MEDICINE RESIDENCY—1100 bed hospital; 3 year approved, active teaching unit of Baylor University College of Medicine; female services, research, cardiology, gastroenterology, renal vascular diseases, hematology, endocrinology, pulmonary function, etc. Board certified specialists in all fields. $2840 to $3550. Must be U. S. citizen. H. D. Bennett, M.D., VA Hospital, Houston, Texas.

PATHOLOGY RESIDENT wanted with one year experience; approved, 2 years; 450 bed hospital; average 5500 surgical specimens and 315 autopsies; quarters available; salary $250 per month, to begin July 1, 1956. Apply: J. D. Kirshbaum, M. D. Pathologist and Director of Laboratories, San Bernardino County Charity Hospital, San Bernardino, California.

ANESTHESIOLOGY RESIDENCY; approved two year residency; integrated with other teaching programs, available July 1, 1956, maintenance and stipend. Apply to: Daniel C. Moore, M. D., Director of Anesthesia, The Mason Clinic and Virginia Mason Hospital, Seattle, Washington.

PHYCHIATRIST WANTED — state hospital, South Blacktoot, Idaho; has opportunity for Board eligible or experienced psychiatrists as director of research and education and as staff psychiatrist, must be eligible for Idaho license; salary competitive; practice involves devoting at least half-time to interview therapy; opportunity for limited private practice; hospital has 800 patients; 8 psychiatrists; 5 clinical psychologists; unique organization for professional work; won 1954 Mental Hospital Achievement Award; only well qualified psychiatrists need apply. Contact: J. O. Cromwell, M.D. Superintendent, Box 390, Blackfoot, Idaho.

PATHOLOGY RESIDENCIES. University of Kansas Medical School and V.A. Hospital; 4 year program for certification, 1 year program for residents other specialties; 12 full time staff pathologists, 10,000 surgicals, 700 autopsies, clinical pathology, research; $1500 to $6000; U.S. citizens preferred. Apply Dr. R. E. Stowell Kansas City 12, Kansas.

PSYCHIATRIC RESIDENCIES—Indiana University Medical Center; are now available; fully-approved for 3 years of psychiatric training in a modern 2500 bed medical center; widely diversified training and experience provided in a 250 bed psychiatric treatment hospital, under Dr. D. F. Moore with rotating services through adjacent campus facilities, including 500 bed Veterans Administration hospital with Dr. E. G. Gogel, Chief of Neuropsychiatry, active university child guidance clinic and a university psychiatric outpatient clinic; ample opportunities for training and consultative services in a variety of university clinics and in 3 other university hospitals, including a children's hospital; broadly oriented university training program with close personal supervision of psychotherapy in clinics and hospitals; impressive interdepartmental opportunities for active clinical and allied basic research in a new psychiatric research institute and for teaching and supervisory experience in the medical school and its affiliated training programs in the social sciences; stipend for 1st year, $4380, increasing proportionately to 3rd year $5760; eligibility for state licensure required for appointment. Write: J. I. Nurnberger, M.D., Department of Psychiatry, Indiana University Medical Center, Indianapolis, Indiana.

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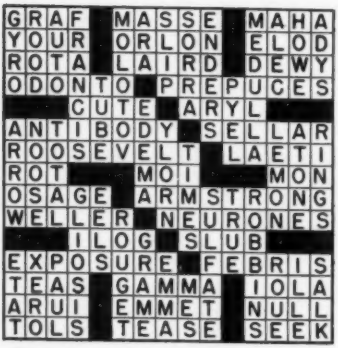
RESIDENT RELAXER

(puzzle on page 17)



WHAT'S THE DOCTOR'S NAME?

(from page 121)

The doctor is Robert ("Bobby") Brown.

VIEWBOX DIAGNOSIS

(from page 15)

MARIE STRUMPELL'S DISEASE

Note the ossification of the longitudinal ligaments forming a rigid bamboo spine. Also note closure at the sacro-iliac joints.

"MEDIQUIZ" ANSWERS

(from page 122)

1(C), 2(B), 3(D), 4(D), 5(B), 6(C), 7(D), 8(A), 9(D), 10(C), 11(A), 12(D), 13(D), 14(C), 15(D), 16(B), 17(B), 18(A), 19(D), 20(C), 21(C).

Resident Physician
Advertisers' Index
April 1956

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1. Elman, R., et al.: Ann. Surg. 136: 635, 1952. 2. Elman, R.: J.A.M.A. 128: 659, 1945.

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